MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2.3.10a.11.12.13.14 FilmG220 10-1-57ert

9758

CERTIFICATE OF DEATH

Reg. Dist. No. 09750

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md Virginia — b. COUNTY: Prince George/ ?
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington Va. 83X-3
d. STREET ADDRESS: Key 1801 K Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mamie Mayme — Middle Allen — Last
4. DATE OF DEATH: Month Sept — Day 25 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10b. KIND OF BUSINESS OR INDUSTRY: Gov. Employee
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. B. Nalls
14. MOTHER'S MAIDEN NAME: Josephine Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Infarction
DUE TO (b): Cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
332X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/19, 1957, to 9/25, 1957, that I last saw the deceased alive on 9/25, 1957, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George H. McLain M.D. — ADDRESS (Street, city or town, state): 1746 K. N.W. Wash 6 D.C. — DATE SIGNED
PHYSICIAN'S NAME (Type): George H. McLain. — Dr. George McLain

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/28/57
22c. NAME OF CEMETERY OR CREMATORY: Manassas Cemetery
22d. LOCATION (City, town, or county) (State): Manassas Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: SEP 27 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09751

9759 CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—.53

1. PLACE OF DEATH:
COUNTY Prince Georges MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
LENGTH OF STAY (in this place) 1 mo-
HOSPITAL OR INSTITUTION OR STREET ADDRESS Nursing Home 2601 Chesterfield av.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE D.C. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x3
STREET ADDRESS (If rural give location) 3414 20th St. N.E.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Ann (Last) Buffort

4. DATE OF DEATH: (Month) Sept. (Day) 4 (Year) 1957

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: Aug 19, 1870
9. AGE last birthday 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hedgman Crouch
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: William E. Doherty.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 IMMEDIATE CAUSE (A) Generalized arteriosclerosis — 6 yrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture Hip — 6 mos

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/9, 1957 to 9/4, 1957, that I last saw the deceased alive on 9/3, 1957, and that death occurred at M, from the causes and on the date stated above.
SIGNATURE John Kelly M. D.
ADDRESS Chevy
DATE SIGNED 9/4/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept 7, 57
NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
LOCATION (City, town, or county) (State) Suitland, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 4, 57
REGISTRAR'S SIGNATURE Carrie Campbell
24. FUNERAL DIRECTOR W. W. Chambers Co.
ADDRESS Washington, D.C.

9/4/57

Dr Maloney - Dep. Mex Dom - Called & Appeared

W. W. Chamberlain

By [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9760

CERTIFICATE OF DEATH

09752

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainer Cheverly
c. LENGTH OF STAY IN 1b: D.C.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainer
d. STREET ADDRESS: 4206 Rainer Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle V. Last Ax

4. DATE OF DEATH: Month 9 Day 27 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1882

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker - retired

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Accetta

14. MOTHER'S MAIDEN NAME: Vingenza Peteralla

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Name, Address): Caroline Loughton, 4203-32nd St. Mt Rainier, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: hours.
411X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Aortic Stenosis with calcification — ?years
DUE TO
(c): Old Rheumatic Heart Disease — ?years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1956, to Sept. 27, 1957, that I last saw the deceased alive on Sept. 26, 1957, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd L. Claymand M.D. ADDRESS (Street, city or town, state): 6311 Balto Ave, Riverdale Md DATE SIGNED: 9/27/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: ~~Oct.~~ 9/30/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Malloy Funeral Home Inc. ADDRESS: Mt. Rainier, Md.

24a. REC'D BY REGISTRAR DATE: OCT 1 '57

24b. REGISTRAR'S SIGNATURE: [signature]

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09753

9761 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodstown 67X-3
d. STREET ADDRESS: R.F.D. # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James Middle: T Last: Baylor
4. DATE OF DEATH: Month: September Day: 11 Year: 19 57

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 4, 1XXX
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: County School
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs J. I. Baylor, Same as #2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Toxemia and exhaustion — INTERVAL BETWEEN ONSET AND DEATH:
816X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized peritonitis
DUE TO (c): Rupture of the duodenum

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Occupant of an automobile that was in a collision with another car
20c. TIME OF INJURY: Hour: 7:30 p. m. Month, Day, Year: 9/9/ 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route # 301
20f. (City or town): Upper Marlboro (County): P. G. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 11, 1957
EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Sept. 11, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Woodstown N. J.

23. FUNERAL DIRECTOR'S SIGNATURE: District Morticians
ADDRESS (Embalming only): 1760 N. H. ave. D.C.
24a. REC'D BY REGISTRAR: DATE 9-13-57
24b. REGISTRAR'S SIGNATURE: John D. Watson
SEP 13 '57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSME 5M 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09754

Reg. Dist. No.

9762

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capital Heights
d. STREET ADDRESS: 5707 Southern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rose; Middle: Mary; Last: Beaner

4. DATE OF DEATH: Month: September; Day: 19; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 18/57

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months; Days: 1
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Beaner

14. MOTHER'S MAIDEN NAME: Mary Helen ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mary Helen Beaner — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Overlaying of mother
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9240

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Overlaying of mother in bed at home

20c. TIME OF INJURY — Hour a. m.: xxx — Month, Day, Year: 9/ 19 19 57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Capital Heights P. G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 9/19/57

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-21-57
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: John T. Rhines & Co. — ADDRESS: 901 3rd St., S. W.

24a. REC'D BY REGISTRAR — DATE: SEP 23 '57
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09755

Reg. Dist. No.

9763

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Bowie
d. STREET ADDRESS: 129 7th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James; Middle: John; Last: Berbig

4. DATE OF DEATH: Month: September; Day: 2,; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-16-90

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman

10b. KIND OF BUSINESS OR INDUSTRY: Penn. Railroad

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nicholson Berbig

14. MOTHER'S MAIDEN NAME: Malinda Rutherford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Dorothy May Berbig; same address.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
442X
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 2, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/5/57
22c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 9 '57
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9829 **CERTIFICATE OF DEATH**

09756 Reg. Dist. No. 24-2

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland.
c. LENGTH OF STAY IN 1b 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4720- Hudson Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo's. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Oxon Hill, Maryland
d. STREET ADDRESS 2283 - Owens Road S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SADIE Middle B. Last BIVENS
4. DATE OF DEATH Month Sept. Day 22nd. Year 19 57
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH August 11- 1884
9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Oxon Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Dean
14. MOTHER'S MAIDEN NAME Betty Owens [illegible]
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mildred E. DeMar, 4720- Hudson Ave., S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion
420.1
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] 19 [illegible] to Sept 22 19 57, that I last saw the deceased alive on Sept 21, 19 57, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE A Schwartzman M.D. ADDRESS (Street, city or town, state) 2007 Nichols Ave SE DATE SIGNED
PHYSICIAN'S NAME (Type) A. SCHWARTZMAN Wash 20, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 25th 57
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery
22d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- Good Hope Rd. S.E. Washington, D.C.
24a. REC'D BY REGISTRAR DATE SEP 24 1957
24b. REGISTRAR'S SIGNATURE Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9: G22 9764 10/13/57

CERTIFICATE OF DEATH

09757
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Berwyn Heights, Maryland.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital	d. STREET ADDRESS 8922 57th avenue,. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOEL	HOFFMAN	BLACK	September	28,	19 57-

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years Last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white		6/1/~~1887~~ 1888	~~70~~ 69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Civil Engineer	Huntingdon, Penna	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Black	Emma Fryling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Mrs Amratha Manning Camp Hill, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) AND PREVIOUS MYOCARDIAL INFARCTION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY, 1957, to SEPT 24, 1957, that I last saw the deceased alive on 24 SEPT, 1957, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE Leslie H. French M.D. — ADDRESS (Street, city or town, state) 1726 EYE ST. N.W. WASH 6. D.C — DATE SIGNED

PHYSICIAN'S NAME (Type) Leslie H. French — 1726 Eye St N. W. Washington D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/1/57	Riverview Cemetery	Huntingdon Penna

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
F. Gasch's Sons Hyattsville Md.	OCT 1 '57	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9830 **CERTIFICATE OF DEATH** Reg. Dist. No. 09758

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Andrews AFB, Wash. 25, D.C.
c. LENGTH OF STAY IN 1b: See Reverse
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Andrews AFB, Wash. 25, D.C.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Texas
b. COUNTY: Val Verde
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Del Rio 80X-3
d. STREET ADDRESS: 206 Austin Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Edward Last: Boland

4. DATE OF DEATH: Month: September Day: 12 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12 May 1922

9. AGE (In years last birthday): 35 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot, U.S. Air Force

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Air Force

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Deceased - Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 348-12-4210

17. INFORMANT: 4080th Air Base Group
Address: M/Sgt Paul Lock, Laughlin AFB, Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Injuries, multiple, severe, extreme — INTERVAL BETWEEN ONSET AND DEATH: Instant
860X
DUE TO
(b): Aircraft Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Aircraft Crash, Full Particulars Unknown

20c. TIME OF INJURY Hour a. m. 0225 Month, Day, Year: Sept 12 1957

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Andrews AFB

20f. (City or town) Andrews AFB, (County) Prince Georges, (State) Md.

21. I certify that I attended the deceased from See Reverse 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 0225 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Reginald P. McManus M.D.
ADDRESS (Street, city or town, state): 1401st USAF Hospital, Andrews Air Force Base, Washington 25, D.C.
DATE SIGNED: 12 September 1957
PHYSICIAN'S NAME (Type): REGINALD P. MCMANUS CAPT USAF (MC)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-19-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl.
22d. LOCATION (City, town, or county) Arlington, (State) Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: SEP 17 '57
24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

A corrected Certificate of Death will be prepared and forwarded if additional information is received concerning itmes presently indicated as unknown.

CERTIFICATE

I, the undersigned, while in performance of duties as Medical Officer of the Day, for the 1401st USAF Hospital, do hereby certify that I was summoned to the scene of the aircraft accident and found subject officer dead upon my arrival thereat. It is my opinion that death occurred approximately 10 to 15 minutes prior to my arrival.

Item 1c: Unable to determine, aircraft had not landed.

Reginald P. McManus

REGINALD P. MCMANUS
CAPT, USAF (MC)
Attending Physician

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9765

09759 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Beaver Heights
d. STREET ADDRESS: 1702 Kenilworth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Regina — Middle: Leigh — Last: Boston

4. DATE OF DEATH: Month: Sept. — Day: 20, — Year: 1957

5. SEX: Female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 12, 1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days: 51
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **********

10b. KIND OF BUSINESS OR INDUSTRY: **********

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard M. Boston

14. MOTHER'S MAIDEN NAME: Jo-ann Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Jo-ann Boston; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
✓ 491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John D. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 21, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-24-57

22c. NAME OF CEMETERY OR CREMATORY: Harmony Cem.

22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. Ernest Jann
ADDRESS: 1432 4th St N.W.

24a. RECEIVED BY REGISTRAR DATE: SEP 26 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

#178

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09760

9766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchelsville, Md
d. STREET ADDRESS: Box 138 Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: W — Last: Brown

4. DATE OF DEATH: Month: Sept — Day: 18 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-6-86

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Brown

14. MOTHER'S MAIDEN NAME: Maggie Burley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William P. Brown — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
592X
DUE TO
(b): Chronic Glomerular Nephritis 1 month
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 19 57 to Sept 18 19 57 that I last saw the deceased alive on Sept 18 19 57, and that death occurred at 11:15 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. Sugar M.D. — ADDRESS (Street, city or town, state): 4300 Raywood Drive, MT RAINIER, Md. — DATE SIGNED: 9/19/57

PHYSICIAN'S NAME (Type): Samuel J. Sugar, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: 9-21-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Pebs

22d. LOCATION (City, town, or county) (State): Mitchellsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Beese, II — ADDRESS: Cheverly, Md.

24a. REC'D BY REGISTRAR DATE: SEP 24 '57

24b. REGISTRAR'S SIGNATURE: W. Leech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9767

CERTIFICATE OF DEATH

09761
Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Prince George — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md. b. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md. — c. LENGTH OF STAY IN 1b: 1Hr. & ½	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park X2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital	d. STREET ADDRESS: 207 65th Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Baby	Girl	Bullard	Sept.	4	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Sept. 3 1957	2 Hrs yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Kenneth Lee Bullard	Betty Delores Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Betty Bullard Mother	Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Atelectasis

DUE TO (b): Prematurity

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.5

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. p. m. 19			

21. I certify that I attended the deceased from Sept 3, 1957 to Sept 4, 1957 that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 11:30A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyattsville — DATE SIGNED: 9/4/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	Sept 1957	Prince Georges Gen Hosp	Cheverly Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Henry W Penn Jr	Adelphi	SEP 18 57	

1000/254 X V3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9747

CERTIFICATE OF DEATH

09762

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Pr. George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Batuse City, R.D.
d. STREET ADDRESS: 3807 - Parkwood Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Virginia — Last: Burton

4. DATE OF DEATH: Month: Sept — Day: 19 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10 1877

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Tayman

14. MOTHER'S MAIDEN NAME: Jennie t. TAYMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Sam - Tayman — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Arteriosclerosis — 5 yrs +
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 56, to Sept, 19 57, that I last saw the deceased alive on 9/19, 19 57, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Troppe, Jr. M.D.
ADDRESS (Street, city or town, state): 1840 Michigan Ave N.E. Washington D.C.
DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, ~~REMOVAL~~ (Specify)

22b. DATE THEREOF: 9-23-57

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek

22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home - Wash DC
ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 23 '57

24b. REGISTRAR'S SIGNATURE: W. Leavitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9768

09763

CERTIFICATE OF DEATH

Items 10a,11,12,13,14,Film G221, 10/4/57 fcy

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Chapel Oaks
d. STREET ADDRESS: 1310 57th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Hattie — Middle: — Last: Butler

4. DATE OF DEATH: Month: Sept. — Day: 28 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 Mar. 1902

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenwood, S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wister Hughey

14. MOTHER'S MAIDEN NAME: Carrie Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
330x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Ruptured aneurysm of Circle of Willis — 6 hours
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEP 28, 1957, to SEP 28, 1957, that I last saw the deceased alive on SEPT 28 1957, and that death occurred at 2.25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D. — ADDRESS (Street, city or town, state): Mt RAINIER, Md — DATE SIGNED: 9/29/57

PHYSICIAN'S NAME (Type): SAMUEL J.N. SUGAR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: 10/1/57 — 22c. NAME OF CEMETERY OR CREMATORY: Lincoln — 22d. LOCATION (City, town, or county) (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph Barbour — ADDRESS: 48-K St. N.E.

24a. REC'D BY REGISTRAR DATE: 9/25/57 — 24b. REGISTRAR'S SIGNATURE: SEP 30 '57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 9769 **CERTIFICATE OF DEATH** 09764

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 5405 Farragut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle; Last: Cain

4. DATE OF DEATH: Month: 4 Sept.; Day; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 30 Aug 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days: 6
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Jackson Cain

14. MOTHER'S MAIDEN NAME: Anna Fargason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
7625
DUE TO
(b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 30, 1957, to Sept 4, 1957, that I last saw the deceased alive on Sept 4, 1957, and that death occurred at 6.00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyattsville DATE SIGNED: 9/4/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/9/1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gaschs Sons ADDRESS: Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE

24b. REGISTRAR'S SIGNATURE

SEP 11 '57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

2077254 X V3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9831

09765

Reg. Dist. No. 242

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: 6 year

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Suitlands

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3010 Parkway Terrace Drive
d. STREET ADDRESS: 3010 Parkway Terrace Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Claire — Last: Casey

4. DATE OF DEATH: Month: Sept — Day: 30 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 3, 1904

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hugh Casey

14. MOTHER'S MAIDEN NAME: Rachel Davy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John H. Casey — Address: 39 Monticello Rd Alejandria Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive heart fail — INTERVAL BETWEEN ONSET AND DEATH

442x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular renal disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described above, held an Autapsy ☐, Inspection ☒ Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T Boyd M.D.

EXAMINER'S NAME (Type): James T Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Sept 30, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/3/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan — ADDRESS: James T. Ryan, Inc. 317 Pa. Ave., SE DC3

24a. REC'D BY REGISTRAR DATE: OCT 3 1957

24b. REGISTRAR'S SIGNATURE: Carrie Campbell

EJ.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9770

CERTIFICATE OF DEATH

09766
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2627 Nicholson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: — Last: Chandler

4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 May 1922

9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Montana

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: David Flansburg

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Arlie V. Chandler — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive G. I. hemorrhage
587.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Multiple ulceration 1st. prt. duodenum
DUE TO
(c) Acute pancreatic necrosis)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-19, 19 57, to 9-3, 19 57, that I last saw the deceased alive on 9-2, 19 57, and that death occurred at 4.00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ronald Fleischer M.D. — ADDRESS (Street, city or town, state): 5432 QUEENS CHAPEL Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): RONALD S FLEISCHER — HYATTSVILLE, Md — 9/3/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 6, 1957

22c. NAME OF CEMETERY OR ~~CREMATORY~~: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: SEP 9 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11005

9771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO MITCHELLVILLE
d. STREET ADDRESS: / RTE. # 2 - BOX 90
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First NICEY — Middle ANN — Last CLARK

4. DATE OF DEATH: Month SEPT. — Day 30 — Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Tenent.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Granville Pingleton
14. MOTHER'S MAIDEN NAME: Sarah Jane Austin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.:
17. INFORMANT: John B. Pingleton- Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senility & pulse may Cubal — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO
154X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma Rectum — Unknown
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/28, 1957, to 9/30, 1957, that I last saw the deceased alive on 9/30, 1957, and that death occurred at 3:20 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. B. Sasscer M.D.
ADDRESS (Street, city or town, state): Upper Marlboro, Maryland.
DATE SIGNED: 9/30/57.

PHYSICIAN'S NAME (Type): R. B. Sasscer, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/3/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Oak Cemetery
22d. LOCATION (City, town, or county) (State): Mitchellville Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Ritchie Bros. Funeral Home
ADDRESS: Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: OCT 9 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9751

CERTIFICATE OF DEATH

09767 345

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Paint Branch Nursing Home 3120 Powder Mill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 15
d. STREET ADDRESS: 6708 - 44th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Luke — Middle: A — Last: Cole

4. DATE OF DEATH: Month: 9 — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 24, 1873

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government Employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arious Nye Cole

14. MOTHER'S MAIDEN NAME: Zidena Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: S. Elizabeth Cole — Address: 6708 - 44th Ave Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Glomerular nephrite
DUE TO (c): & Cerebral arteriosclerosis

447X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957 to Sept 2, 1957, that I last saw the deceased alive on June, 1957, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Weintraub M.D. — ADDRESS (Street, city or town, state): 30 C Ridge Rd, Greenbelt, Md. — DATE SIGNED: 9/2/57

PHYSICIAN'S NAME (Type): W. C. Weintraub

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/5/57

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The S. H. Hines Co.-2901 14th St., N.W. Wash. DC

24a. REC'D BY REGISTRAR DATE: SEP 4 1957

24b. REGISTRAR'S SIGNATURE: James Lowery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9832 **CERTIFICATE OF DEATH** 09768

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 2 yrs, 1 mo., 30 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 1628 27th St., S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: P.; Last: Conner

4. DATE OF DEATH: Month: 9; Day: 12; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/5/1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months —; Days —
IF UNDER 24 HRS.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James D. Conner

14. MOTHER'S MAIDEN NAME: Mary Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 579-03-4166

17. INFORMANT: Decedent — Address: —

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.,

002x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pulmonary emphysema — 5 yrs.,

DUE TO

(c) Pulmonary tuberculosis — 10 yrs.,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/13/55, to 9/12/57, that I last saw the deceased alive on 9/12/57, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss, M.D. — ADDRESS (Street, city or town, state): Glenn Dale Hospital — DATE SIGNED: 9/12/57

PHYSICIAN'S NAME (Type): Moe Weiss, M. D. — Glenn Dale, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-16-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan #222 — ADDRESS: 32 James T. Ryan Inc. 312 Penn Ave

24a. REC'D BY REGISTRAR DATE: SEP 17 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09769

9833 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Andrews Air Force Base
c. LENGTH OF STAY IN 1b: Unknown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1401ST USAF Hospital (MATS)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington, D.C. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47x3
d. STREET ADDRESS: #6, N. Street S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: William Last: Cousar

4. DATE OF DEATH: Month: September Day: 1 Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12 April 1896

9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rayford, N.C.

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: James Cousar

14. MOTHER'S MAIDEN NAME: Ida Hodges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Clara Cousar Address: #6, N. Street S.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Hours

331X

DUE TO (b): Arteriolar Hypertension — 3 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 September, 1957, to 1 Semptember, 1957, that I last saw the deceased alive on 1 September, 1957, and that death occurred at 11:38 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles L. Picus M.D. ADDRESS (Street, city or town, state): 1401ST USAF Hospital (MATS) DATE SIGNED

PHYSICIAN'S NAME (Type): CHARLES L. PICUS CAPT., USAF (MC) Andrews Air Force Base, Washington 25, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-6-57

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem.

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

24a. REC'D BY REGISTRAR DATE: SEP 4 57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09770

9772

Reg. Dist. No. 231

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2008 R Street N. W.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

47x-3

3. NAME OF DECEASED (Type or print): First: William Edward; Middle; Last: Crump
4. DATE OF DEATH: Month: September; Day: 15; Year: 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 2,1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Clerk
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: William F. Crump
14. MOTHER'S MAIDEN NAME: Elizabeth Reynolds
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Elizabeth Butler, Address 7330 12th N. W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular renal disease
DUE TO
(c)

442x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour: o. m. / p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 15, 1957
EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/18/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Sawyers Sons
ADDRESS: 1756 Pennsylvania Ave. NW, Washington, DC
24a. REC'D BY REGISTRAR DATE: SEP 20 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9773

CERTIFICATE OF DEATH

09771

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Rainier
d. STREET ADDRESS: 4023 37th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Campbell; Last: Dallas

4. DATE OF DEATH: Month: Sept; Day: 13; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 15, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Engineer(Retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Everett J. Dallas

14. MOTHER'S MAIDEN NAME: Elizabeth Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Bessie T. Dallas — Address: Mt. Rainier, Md. 4023 37th Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Edema	1 day
DUE TO (b)	Bronchopneumonia	1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Chronic Coronary Insufficiency	1 year

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260 x Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Sept, 1957, that I last saw the deceased alive on Sept 13, 1957, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Benjamin S. Miller M.D. ADDRESS (Street, city or town, state): 3324-34th St Mt Rainier DATE SIGNED: Sept 13 1957

PHYSICIAN'S NAME (Type): Benjamin S. Miller

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/17/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: The S. H. Hines Co.-2901 14th St., N.W. Wash. DC

24a. REC'D BY REGISTRAR DATE: SEP 16 '57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9774

CERTIFICATE OF DEATH

09772

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COTTAGE CITY
d. STREET ADDRESS: 3704 - 37th. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle W. — Last DEANE

4. DATE OF DEATH: Month SEPTEMBER — Day 24 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 21, 1895

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Julian W. Deane

14. MOTHER'S MAIDEN NAME: Ella Riehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 578 10 5762

17. INFORMANT: Vivian M Deane — Address: Cottage City Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

592x

DUE TO (b): Chronic Nephritis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1957, to 9/24, 1957, that I last saw the deceased alive on 9/24, 1957, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A Deitz — M.D. — ADDRESS (Street, city or town, state): Hyattsville Md — DATE SIGNED: 9-24-57

PHYSICIAN'S NAME (Type): A Deitz

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/27/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. RECD BY REGISTRAR DATE: SEP 27 1957

24b. REGISTRAR'S SIGNATURE: W. Heinrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9775

CERTIFICATE OF DEATH

Reg. Dist. No. 09773

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4405-40th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood 34
d. STREET ADDRESS: 4405-40th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maurice — Middle: C. — Last: Dent

4. DATE OF DEATH: Month: Sept. — Day: 14 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/5/902
9. AGE (If years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cressman
10b. KIND OF BUSINESS OR INDUSTRY: Darby Co.
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin A. Dent
14. MOTHER'S MAIDEN NAME: Roberta E. Calvert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-01-2855
17. INFORMANT: Malcolm A. Dent — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Esophagus — INTERVAL BETWEEN ONSET AND DEATH: about one year
DUE TO
150X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1, 1956 to Sept. 14, 1957, that I last saw the deceased alive on Sept. 14, 1957, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Williams, Jr. M.D. — ADDRESS (Street, city or town, state): 35 New York Ave. NW. — DATE SIGNED
PHYSICIAN'S NAME (Type): R.S. WILLIAMS — Wash. 1, D.C. — 9/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/17/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Valley's Funeral Home, Inc. — ADDRESS: Mt. Rainier, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 18 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09774

Reg. Dist. No.

FOR STATE HEALTH DEPT.

9834

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Foote
c. LENGTH OF STAY IN 1b: Summer
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 329-11th Street SW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert Middle Thomas Last Dickerson
4. DATE OF DEATH: Month Sept Day 28 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 27, 1901
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Hand
10b. KIND OF BUSINESS OR INDUSTRY: Shipping
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benjamin Alexander Dickerson
14. MOTHER'S MAIDEN NAME: Esther Talmadge
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Bessie Carter — Address: 316 11th St. SE Washington DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
851X
DUE TO (b): Drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell from a tugboat into river
20c. TIME OF INJURY: Hour 2:30 a.m. p.m. — Month, Day, Year: 9-25 1957
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River
20f. (City or town) Near Alexandria (County) (State) Va

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James H Boyd M.D.
EXAMINER'S NAME (Type): James I Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept 28, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/1/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county): Suitland (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. W. Chambers Co 517 11th St SE
24a. REC'D BY REGISTRAR — DATE: OCT 4 '57
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9776

09775

Reg. Dist. No. 231

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X O Glen Arden
d. STREET ADDRESS: 7th and Lincoln Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Le Roy; Middle: ; Last: Dock
4. DATE OF DEATH: Month: September; Day: 29; Year: 19 57
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 2, 1908
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Dock
14. MOTHER'S MAIDEN NAME: Lena Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gladys Dock; same address — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:
442 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m.; Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 29, 1957
EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: Evergreen
22d. LOCATION (City, town, or county) (State): Bladensburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Henry D Washington & Son 467 N. St. NW. DC
24a. REC'D BY REGISTRAR DATE: OCT 3 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9777 Items 7,10a, 11,12,13,14 FilmG220 9-24-57 et 09776

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, 14
d. STREET ADDRESS: 5103 Navahoe St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: ; Last: Douglas

4. DATE OF DEATH: Month: Sept; Day: 15; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-14-08

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months; Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pastry Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rockhill, S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Epherfon Douglas

14. MOTHER'S MAIDEN NAME: Georgianne Douglas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Pul. embolism
610X
DUE TO (b): Benign prostatic hypertrophy.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): c prostatectomy

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/23, 1957, to 9/15, 1957, that I last saw the deceased alive on 9-5, 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D. ADDRESS (Street, city or town, state): 4300 KAYWOOD DR DATE SIGNED: 9-16-57

PHYSICIAN'S NAME (Type): SAMUEL J.N. SUGAR MT RAINIER, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/20/57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Benning Rd SE

23. FUNERAL DIRECTOR'S SIGNATURE: Johnson & Jenkins ADDRESS: 4804 Ga Ave

24a. REC'D BY REGISTRAR DATE 1957

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09777

9835

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Prince Georges
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale
c. LENGTH OF STAY IN 1b: 34 mos 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47x-3
d. STREET ADDRESS: 210 C St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edmund; Middle: R.; Last: Downey

4. DATE OF DEATH: Month: Sept. Day: 1 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11/14/1889

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): News Vendor

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Downey

14. MOTHER'S MAIDEN NAME: Mary Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: deceased
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.
002x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cor pulmonale; Cirrhosis of the Liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 8, 1954, to Sept 1, 1957, that I last saw the deceased alive on Sept. 1, 1957, and that death occurred at 6:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss M.D. — ADDRESS (Street, city or town, state): Glenn Dale Hospital, Glenn Dale, Maryland — DATE SIGNED: 9/1/57

PHYSICIAN'S NAME (Type): Moe Weiss M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-4-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walsh Funeral Home 741-11th St. S.E. Wash D.C.

24a. REC'D BY REGISTRAR DATE: SEP 4 57

24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9778

CERTIFICATE OF DEATH

09778
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly Md
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mass
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlemont 58X-3
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Alfred Last: Dunlop

4. DATE OF DEATH: Month: 9 Day: 2 Year: 1957

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-15-1935

9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technical Illustrator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bayshore, L.I.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Leslie R. Dunlop

14. MOTHER'S MAIDEN NAME: Marion E. Dickover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Marion Dunlop-Charlemont, Mass.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic acidosis
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Diabetic Mellitus.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1-, 1957, to 9-2, 1957, that I last saw the deceased alive on 9-2-, 1957, and that death occurred at 8:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert Cotte M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation
22b. DATE THEREOF: 9/3/57
22c. NAME OF CEMETERY OR CREMATORY: Greenfield
22d. LOCATION (City, town, or county) (State): Massachusetts

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons
ADDRESS: Hyattsville, Maryland.

24a. REC'D BY REGISTRAR DATE: 9-4-57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9779

CERTIFICATE OF DEATH

Reg. Dist. No. 09779

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Greenbelt
d. STREET ADDRESS: 10 S Plateau Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise — Middle: M — Last: Eastman
4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 19 57
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6 Sept 1882
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: S.S. Penney
14. MOTHER'S MAIDEN NAME: Unk/
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Ruth Mac Kenzie — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction occipital Lobe.
420.0
DUE TO (b): both cerebral Hemispheres
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive arteriosclerotic Heart Dis.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-28 19 57 to 9/3 19 57 that I last saw the deceased alive on 9/3 19 57, and that death occurred at 6,12A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Til Bergman M.D. — ADDRESS (Street, city or town, state): Hyattsville, Md. — DATE SIGNED: Sept. 3, 1957

PHYSICIAN'S NAME (Type): Til Bergman — Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 9/3/57.
22c. NAME OF CEMETERY OR CREMATORY: Leete Funeral Home
22d. LOCATION (City, town, or county) (State): Guilford, Conn.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
24a. RECD. BY REGISTRAR DATE: SEP 5 57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9748

CERTIFICATE OF DEATH

Reg. Dist. No. 09780b

1. PLACE OF DEATH a. COUNTY: Prince George — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park — c. LENGTH OF STAY IN 1b: 4 wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Point Branch Nursing Home	d. STREET ADDRESS: 1923 Jackson St., N.E. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Wilmer Middle: Adam Last: Eisenhart	4. DATE OF DEATH Month: Sept. Day: 17 Year: 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 11, 1888	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	U. S. Govt	York Co., Penn.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Eisenhart	Susan Kauffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Nursing home records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	2 hrs
DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)		

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral thrombosis (old)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 23, 1957, to Sept 17, 1957, that I last saw the deceased alive on Sept 10, 1957, and that death occurred at 1:58 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James [illegible] M.D. — ADDRESS (Street, city or town, state): 7701 Carroll Ave Takoma Park, 12, Md. — DATE SIGNED: 9-17-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
removal	9/19/57	Prospect Hill Cemetery	York, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
The S.H. Hines Company,	2901 14th St. N.W. Washington, D.C.	SEP 20 1957	a. W. Hedrick

27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 2 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9752

CERTIFICATE OF DEATH

Reg. Dist. No. 09784 5

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b 16 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Jefferson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Same b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Same
d. STREET ADDRESS 1 Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EDITH Middle LURA Last EMACK

4. DATE OF DEATH Month Sept Day 16 Year 19 57

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan 5 1864
9. AGE (In years last birthday) 93 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY own Home
11. BIRTHPLACE (State or foreign country) Cleveland - Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Alfred W French
14. MOTHER'S MAIDEN NAME Ellen E. Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.
16. SOCIAL SECURITY NO. None
17. INFORMANT Ellen Emack Address same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) GENERALIZED ARTERIOSclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Cerebral Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1955, to Sept, 1957, that I last saw the deceased alive on Sept 4, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. [signature] ADDRESS (Street, city or town, state) 4713 Thomas Dr College Park Md DATE SIGNED 9-16-57

PHYSICIAN'S NAME (Type) W. A. ETIENNE

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/18/57
22c. NAME OF CEMETERY OR CREMATORY St John's Cemetery
22d. LOCATION (City, town, or county) (State) Beltsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Maryland
24a. REC'D BY REGISTRAR DATE SEP 19 1957
24b. REGISTRAR'S SIGNATURE James Sweeney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09782

9789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md.
c. LENGTH OF STAY IN 1b: 8 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
d. STREET ADDRESS: 6007 Forest Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laurence; Middle: ; Last: Fielding

4. DATE OF DEATH: Month: Sept; Day: 23; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-5-93

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railway Mail Clerk

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Leslie F. Fielding

14. MOTHER'S MAIDEN NAME: Laura Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Cheverly, Md.
Laurence F. Fielding 6007 Forest Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
420.1
DUE TO
(b): Coronary atherosclerosis — Unknown
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1953, 19____, to Sept 23, 1957 that I last saw the deceased alive on 23 Sept, 1957, and that death occurred at 8:05 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John K Kehoe M.D. — ADDRESS (Street, city or town, state): Cheverly Md — DATE SIGNED: 9/24/57

PHYSICIAN'S NAME (Type): Dr. John Kehoe

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/26/57

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Prince Georges Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. H. Hines Co — ADDRESS: 901-14 St. N.W.

24a. REC'D BY REGISTRAR — DATE: SEP 25 '57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9781 **CERTIFICATE OF DEATH** 09783

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Landover Hills Md
d. STREET ADDRESS 4707-66th. Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mildred Middle Last Filbey

4. DATE OF DEATH Month Sept. Day 11 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 15 1910
9. AGE (In years last birthday) 47 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) South Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Hannah
14. MOTHER'S MAIDEN NAME Hattie Gilmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Address Charles A. Filbey Landover Hills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of L. BREAST — INTERVAL BETWEEN ONSET AND DEATH 3 years
170 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1954, to 9-11-, 1957, that I last saw the deceased alive on 9-10-, 1957, and that death occurred at 10:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Albert Roth M.D. ADDRESS (Street, city or town, state) 5510 Macon St, Riverdale, Md DATE SIGNED 9-11-57

PHYSICIAN'S NAME (Type) Albert Roth

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/13/57
22c. NAME OF CEMETERY OR CREMATORY Lot Lincoln
22d. LOCATION (City, town, or county) (State) Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE F. Hauch Sons ADDRESS Hyattsville Md
24a. REC'D BY REGISTRAR DATE SEP 13 57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9782

11021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly,
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Lanham
d. STREET ADDRESS: Box 310
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Girl — Middle: — Last: Fletcher

4. DATE OF DEATH: Month: Sept — Day: 11 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-10-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours: 2 — Min.: 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hyland Fletcher

14. MOTHER'S MAIDEN NAME: Cora Chittams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: From birth
761.0
DUE TO (b): Maternal Cause — Breech extraction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/10/ 19 57 to 9/11/ 19 57 that I last saw the deceased alive on 9/11/ 19 57, and that death occurred at 6:35P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton, Hyatts — DATE SIGNED: 9/14/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10/11/57

22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital

22d. LOCATION (City, town, or county) (State): Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry [illegible] Penn, Jr. Agent — ADDRESS: Cheverly, Md.

24a. REC'D BY REGISTRAR DATE: OCT 16 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

20773 57 X V5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9783 **CERTIFICATE OF DEATH** 09784 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PrinceGeorges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant,
d. STREET ADDRESS: 502 68th Pl.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: H. — Last: Fones
4. DATE OF DEATH: Month: Sept — Day: 4 — Year: 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 1, 1881
9. AGE (In years last birthday): 76. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Adjudicator- Vet.Adm.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry H. Fones
14. MOTHER'S MAIDEN NAME: --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Sarah A. Fones — Address: 502 68th Place Seat Pleasand, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac-Respiratory Failure
DUE TO (b): Carcinoma of Stomach c
DUE TO (c): Generalized Metastases
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 7 Mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 8, 19 57, to SEPT- 4, 19 57, that I last saw the deceased alive on SEPT- 4, 19 57, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Max M. Herzberg M.D. — ADDRESS (Street, city or town, state): Seat Pleasant Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Max M. Herzberg-- 7016 Greig Street, Seat Pleasant, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/9/1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.-2901 — ADDRESS: Wash.D.C. 14th St.,N.W.
24a. REC'D BY REGISTRAR DATE: SEP 17 '57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9784

Item 14, Film G220, 9/26/57 rcv

CERTIFICATE OF DEATH

09785

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PRINCE GEORGE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 7421 17th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles; Middle: H; Last: Friedman

4. DATE OF DEATH: Month: Sept; Day: 21; Year: 1957

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 15, 1882

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Julius Friedman

14. MOTHER'S MAIDEN NAME: Cera Fay Friedman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Herbert Friedman — Address: N. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock and pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial infarction due thrombosis — 6 hrs.
DUE TO
(c) Coronary atherosclerosis — 3 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to Sept 21, 1957, that I last saw the deceased alive on Sept 21, 1957, and that death occurred at 3:52 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lund Lentsky, M.D. — ADDRESS (Street, city or town, state): 3408 Rhode Island; Mt Rainier, Md. — DATE SIGNED: Sept 21, 1957

PHYSICIAN'S NAME (Type): Leon R. Levitsky MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: 9-24-57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Norfolk Va

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee's Sons — ADDRESS: Wash. D.C.

24a. REC'D BY REGISTRAR DATE: SEP 24 57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9785 CERTIFICATE OF DEATH

Reg. Dist. No. 09786245

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIVERDALE
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ...ELAND MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Va. — b. COUNTY: Prince Williams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Triangle 83x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle ODEL Last GARRISON

4. DATE OF DEATH: Month Sept. Day 13, Year 1957

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 9-19-1895 — 9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Bridewell
14. MOTHER'S MAIDEN NAME: Addie Garrison?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records — Address: Riverdale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Parkinsons Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
350 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): General Arteriosclerosis — 2 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 21, 1957, to Sept 13, 1957, that I last saw the deceased alive on Sept 12, 1957, and that death occurred at 5 55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L W Malin M.D. — ADDRESS (Street, city or town, state): Riverdale Md — DATE SIGNED: 9-13-57

PHYSICIAN'S NAME (Type): L W Malin M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/16/57
22c. NAME OF CEMETERY OR CREMATORY: Plumfree Cemetery
22d. LOCATION (City, town, or county) (State): Plumfree Va

23. FUNERAL DIRECTOR'S SIGNATURE: F Gasch & Sons — ADDRESS: Hyattsville Md

24a. REC'D BY REGISTRAR DATE: SEP 16 1957
24b. REGISTRAR'S SIGNATURE: James Lecraw

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9836

CERTIFICATE OF DEATH

Reg. Dist. No. 097845

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) HYATTSVILLE
c. LENGTH OF STAY IN 1b 45 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) HYATTVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First HATTIE Middle MARY Last GILBERT

4. DATE OF DEATH Month Sept Day 27 Year 1957

5. SEX F

6. COLOR OR RACE Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH OCT 30 1887

9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months 10 Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC

11. BIRTHPLACE (State or foreign country) N.C.

12. CITIZEN OF WHAT COUNTRY? AMER.

13. FATHER'S NAME SAMUEL H. STITT

14. MOTHER'S MAIDEN NAME ELLA E. CAMPBELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Info Refuses

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTISIS to LIVER & LUNG
DUE TO
(b) CARCINOMA OF STOMACH
DUE TO
(c)

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
(a) —
(b) 17 months
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH --, 1957, to SEPT 27 1957, that I last saw the deceased alive on SEPT 27, 1957, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W S Hudson M.D.
ADDRESS (Street, city or town, state) 509 Rhode Island NW WASHINGTON DC
DATE SIGNED 9-27-57
PHYSICIAN'S NAME (Type) W. S. HODSON

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 10-2-57

22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

22d. LOCATION (City, town, or county) Washington DC (State)

23. FUNERAL DIRECTOR'S SIGNATURE Ambrose B Boyd
ADDRESS 1238 20th St NW

24a. REC'D BY REGISTRAR DATE SEP 30 1957

24b. REGISTRAR'S SIGNATURE James Lowry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9753

CERTIFICATE OF DEATH

09788 345

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2612 Kirkwood Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville Md.
d. STREET ADDRESS: 2612 Kirkwood Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Josephine — Last: Giles

4. DATE OF DEATH: Month: sept — Day: 6 — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 16, 1886

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles W. Fields

14. MOTHER'S MAIDEN NAME: Hortense Cabell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alice G. Walling — Address: Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ulcerative colitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
572.2
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): —
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. fl. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5, 1955, to 9/6, 1957, that I last saw the deceased alive on 9/6, 1957, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl W. Graff M.D. — ADDRESS (Street, city or town, state): 2716 Kirkwood Place — DATE SIGNED:

PHYSICIAN'S NAME (Type): EARL W. GRAEFF M.D. — W. Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/9/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 9 1957

24b. REGISTRAR'S SIGNATURE: James Lavery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9749

09789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md.

c. LENGTH OF STAY IN 1b: 34 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 College Park, Md.

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 8510 Baltimore avenue,.

d. STREET ADDRESS: 8510 Baltimore avenue,.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lawrence Middle Cunningham Last Gingell

4. DATE OF DEATH: Month September Day 24, Year 19 57.

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 6, 1879

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto & general store

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Gingell

14. MOTHER'S MAIDEN NAME: Mary Lowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Clara M. Gingell College Park, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, 19____, to ____, 19____, that I last saw the deceased alive on 8-22-57, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W.C. Etienne M.D. — ADDRESS (Street, city or town, state): 4113 Kenyon St College Park Md — DATE SIGNED: 9-24-57

PHYSICIAN'S NAME (Type): W.C. ETIENNE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/26/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Maryland.

24a. REC'D BY REGISTRAR DATE: SEP 26 '57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use os the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

SEP 26 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, Film G221, 10/4/57 fcy

CERTIFICATE OF DEATH

9786

09790 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Suitland
d. STREET ADDRESS: 3158 Parkway Ter
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Caroline Middle: Last: Gittings

4. DATE OF DEATH: Month: Sept. Day: 28 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 23 Jan 1876
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John H. Granger
14. MOTHER'S MAIDEN NAME: Dellia Conway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Mary E. Anderson 3017 Mass. Ave. S.E. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive GI Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 Hours

DUE TO

600.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: multiple gastric ulcers. — 4 8 hours

(c) Pernicious Anemia — 6-8 mths

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 10, 1957, to Sept 28, 1957 that I last saw the deceased alive on Sept 28, 1957, and that death occurred at 5:30 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: William Brain M.D. ADDRESS (Street, city or town, state): 612 4 Central Ave DATE SIGNED: 9/28/57

PHYSICIAN'S NAME (Type): WM BRAIN Capitol Hgts Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/1st/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Talley's Funeral Home Inc. ADDRESS: Mt. Rainier, Md.

24a. REC'D BY REGISTRAR DATE: OCT 1 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9787

CERTIFICATE OF DEATH

09791

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly

c. LENGTH OF STAY IN 1b: 53 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Riverdale

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 77 PrinceGeorges General Hospital

d. STREET ADDRESS: 5602 54th Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maude Middle Last Gray

4. DATE OF DEATH: Month Sept. Day 28 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 15 Aug. 1880

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Harry L. Wood

14. MOTHER'S MAIDEN NAME: Amanda V. Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address: Cheverly, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulm. Cong. & Edema

DUE TO (b): Uremia (Renal failure. Left Kidney.

DUE TO (c): Arteriosclerosis & Cardiac Stenosis

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) Unknown 2 days; (b) 10 do.; (c) Unk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 4, 1957, to Sept 27, 1957, that I last saw the deceased alive on Sept 27, 1957, and that death occurred at 5.30AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon W Kelley M.D. ADDRESS (Street, city or town, state): 6124 41st Ave Hyatts. Md DATE SIGNED: 9/28/57

PHYSICIAN'S NAME (Type): Dr. Kelly 6124 41th St Hyattsville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 30, 1957

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: OCT 1 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9837 **CERTIFICATE OF DEATH** 09792

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avondale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2101 Brighton Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avondale ×2
d. STREET ADDRESS: 2101-Brighton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: M. — Last: Greene

4. DATE OF DEATH: Month: Sept. — Day: 5 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/11/1876

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Attorney, U.S.Govt.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): E.Greenwich, R.I.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel P. Greene

14. MOTHER'S MAIDEN NAME: Julia A. Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Jennie M. Greene — Address: Avondale, Md. 2101 Brighton Road,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, head of pancreas, — INTERVAL BETWEEN ONSET AND DEATH: 4-6 mos.
DUE TO
157×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): metastases to small bowel
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from March 12 1957, to Sept 5, 1957, that I last saw the deceased alive on Sept 5, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank R. Shea, M.D. — ADDRESS (Street, city or town, state): 4100 - 22nd St. N.E. — DATE SIGNED:

PHYSICIAN'S NAME (Type): FRANK R. SHEA, M.D. — Washington 18 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 9/7/57

22c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Pr.Geo.Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., — ADDRESS: Wash. D.C. 2901 14th St.N.W.

24a. REC'D BY REGISTRAR DATE: SEP 17 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9853 (Void)

Reg. Dist. No. 09793 43

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Route # 301

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): X/ Mitchellville
d. STREET ADDRESS: / Route # 301
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edith Middle: Pearl Last: Harrison
4. DATE OF DEATH: Month: September Day: 23 Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 17, 1886
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Wesley Chaney
14. MOTHER'S MAIDEN NAME: Edith Deale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: G. Marvin Harrison, Mitchellville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH:

442 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Cardiovascular renal disease

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [ ], Inquiry [ ]; and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: James I. Boyd M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: September 23, 1957

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/26/57
22c. NAME OF CEMETERY OR CREMATORY: St. Barnabas Cemetery
22d. LOCATION (City, town, or county) (State): Leland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: Upper
Ritchie Bros. Funeral Home-Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: SEP 30 1957
24b. REGISTRAR'S SIGNATURE: Agnes Gaughey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9788 **CERTIFICATE OF DEATH** 09794

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 33 BLADENSBURG
d. STREET ADDRESS: 4110 - 53rd. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MRS MYRTA Middle: Lost: HAUGHT
4. DATE OF DEATH: Month: Sept Day: 27 Year: 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 4, 1882
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Jonas Rice Stevenson
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Priest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: John S. Haught Address: Hyattsville Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis	1 month
DUE TO		
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. (b)	Carcinoma of the breast	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1952, to Sept 27, 1957, that I last saw the deceased alive on Sept 27, 1957, and that death occurred at 11:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Norman Donat Comeau M.D. ADDRESS (Street, city or town, state): 3503 Penny ST DATE SIGNED: 9/27/57

PHYSICIAN'S NAME (Type): NORMAN DONAT COMEAU MT RAINIER MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation
22b. DATE THEREOF: on 9/28/57
22c. NAME OF CEMETERY OR CREMATORY: Clarksburg
22d. LOCATION (City, town, or county) (State): West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville Maryland.
24a. REC'D BY REGISTRAR DATE: SEP 30 '57
24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9789 — 09795 — Reg. Dist. No. 245

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs-Wheaton, Maryland.
d. STREET ADDRESS: 2909 Ivydale St 1556.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth — Middle Jane — Last Hill
4. DATE OF DEATH: Month Sept — Day 7, — Year 1957.
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 16, 1929
9. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Vincent Lanzillotti
14. MOTHER'S MAIDEN NAME: Gilda Incutti

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 578-38-1296
17. INFORMANT — Address: Mrs Vincent A Lanzillotti Silver Springs, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Crushed chest
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in an automobile in collision with a bridge,
20c. TIME OF INJURY: Hour 5.45 p.m. — Month, Day, Year 9-7- 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Beltsville (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John D. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John T. Maloney, M.D.
DATE SIGNED: Sept. 8, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/11/57
22c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey,
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: SEP 10 1957
24b. REGISTRAR'S SIGNATURE: James Cooney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9750

CERTIFICATE OF DEATH

09796

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7406 Dartmouth Avenue,.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md
d. STREET ADDRESS 7406 Dartmouth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Florence Middle Rutherford Last Hill

4. DATE OF DEATH Month Sept Day 29, Year 19 57.

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH June 14, 1896

9. AGE (In years last birthday) 61 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Connecticut

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John Rutherford

14. MOTHER'S MAIDEN NAME Amelia Fladd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Ruth Lutwack Address College Park, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 day

420.0

DUE TO (b) Arterio-sclerotic heart disease — 5 yr +

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 19 56, to Sept. 19 57, that I last saw the deceased alive on Sept. 26, 19 57, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W.C. Etienne M.D. ADDRESS (Street, city or town, state) 4713 Berwyn Rd DATE SIGNED

PHYSICIAN'S NAME (Type) W.C. ETIENNE College Park, Md 9-30-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation

22b. DATE THEREOF 9/30/57

22c. NAME OF CEMETERY OR CREMATORY Norwood

22d. LOCATION (City, town, or county) Massachusetts (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Maryland.

24a. REC'D BY REGISTRAR DATE OCT 4 '57

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9839 **CERTIFICATE OF DEATH** 09797

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges' — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park
c. LENGTH OF STAY IN 1b: 13 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6523 - Coolidge St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges'
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maryland Park x2
d. STREET ADDRESS: 6523 - Coolidge St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle VIRGINIA Last Hogue

4. DATE OF DEATH: Month 9 - Day 27 - Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 27, 1885
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Walter H. White
14. MOTHER'S MAIDEN NAME: Cora V. Hoyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Faith Evans — Address: 3601 Wis. Ave. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	1 hour
420.0 DUE TO (b)	Arteriosclerotic heart disease	3 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	General Arteriosclerosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 7, 1957, to Sept 27, 1957, that I last saw the deceased alive on Sept 25, 1957, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Van Natta M.D. — ADDRESS (Street, city or town, state): 5440 Silver Hill Rd — DATE SIGNED

PHYSICIAN'S NAME (Type): PAUL VAN NATTA MD — 7 Washington Circle

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-30-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. W. Chambers Co. 517-11th St. S.E.
24a. REC'D BY REGISTRAR DATE: OCT 1 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09798

9790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ~~Anne~~, Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 13 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Riverdale,
d. STREET ADDRESS: 5314 Riverdale Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ~~Anne~~, Middle Morton Zopher, Last Hunt

4. DATE OF DEATH: Month Sept. Day 5 Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-1-15
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morton P. Hunt
14. MOTHER'S MAIDEN NAME: Launa Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-34-4941
17. INFORMANT: Grace E. Hunt (Wife) — Address: Same As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1957, to Sept, 1957, that I last saw the deceased alive on Sept 5, 1957, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon W Kelley M.D. — ADDRESS (Street, city or town, state): 6124-41st Ave Hyatts. Md — DATE SIGNED: 9/5/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-7-57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
22d. LOCATION (City, town, or county) (State): Colmar Manor, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons, ADDRESS: Hyattsville, 4739 Balto. Ave.
24a. REC'D BY REGISTRAR DATE: SEP 9 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09799

9791 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Hill
d. STREET ADDRESS: 6607 Boxley Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: R — Last: Hurley

4. DATE OF DEATH: Month: Sept. — Day: 27 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-10-1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Elevator

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Hurley

14. MOTHER'S MAIDEN NAME: Annie Devine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Robert E. Hurley — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
331X
DUE TO
(b): Generalized Arteriosclerosis — Unknown
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Cystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/1/54 to 7/27/57, that I last saw the deceased alive on 9/26/57, and that death occurred at 1,50 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Lynn M.D. — ADDRESS (Street, city or town, state): 5241 St Barnabas Rd — DATE SIGNED: 9/22/57

PHYSICIAN'S NAME (Type): John T. Lynn

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-30-57

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem.

22d. LOCATION (City, town, or county) (State): Bladensburg Rd Wash D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm Lee Sons — ADDRESS: 300-4½ St N.E.

24a. REC'D BY REGISTRAR — DATE: SEP 30 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09800 345

FOR STATE HEALTH DEPT. 9792

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 337 Howard Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dorothy — Middle Elizabeth — Last Hutchinson

4. DATE OF DEATH: Month September — Day 7 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-8-20
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Bd. of Education
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie S. McGaha
14. MOTHER'S MAIDEN NAME: Annie Ray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Oda S. McGaha; 3616 Powder Mill Rd. Beltsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Compound comminuted fracture of skull and facial bones, Lacerations, multiple and severe — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (c): Automobile accident — INTERVAL BETWEEN ONSET AND DEATH:

823X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in an automobile in collision with a bridge.
20c. TIME OF INJURY (Hour, Month, Day, Year): 5.45 P.M. 9-7-57 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Beltsville, Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John T. Maloney, M.D.
DATE SIGNED: Sept. 7, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/11/57
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: REC'D 10 1957
24b. REGISTRAR'S SIGNATURE: James Severs

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9840

Reg. Dist. No. 09801

1. PLACE OF DEATH
a. COUNTY: Prince Georges
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (Rural)
c. LENGTH OF STAY IN 1b: 2 months and 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Maryland~~ D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1327 - Harvard St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: L.; Last: Ingram

4. DATE OF DEATH: Month: Sept.; Day: 11; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/23/99

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Savana, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John William Ingram

14. MOTHER'S MAIDEN NAME: Annie Lester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 227-09-7914

17. INFORMANT: Decedent
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 months
162X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis
002X
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 21, 19 57, to Sept., 11, 19 57, that I last saw the deceased alive on Sept., 11, 19 57, and that death occurred at 3:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Moe Weiss, M.D.
ADDRESS (Street, city or town, state): Glenn Dale Hospital
DATE SIGNED: 9-11-57

PHYSICIAN'S NAME (Type): Moe Weiss
Glenn Dale, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 9/12/57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State): Danville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Jos. Hamlet's Sons
ADDRESS: 1752 Pa. Ave. N.W.

24a. REC'D BY REGISTRAR DATE: SEP 17 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9793

11034 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 Hrs 15 Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Geofges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham, XO
d. STREET ADDRESS: Box 217
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Willie; Middle: ; Last: Jackson

4. DATE OF DEATH: Month: Sept; Day: 14; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-11-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 1; Days: 3
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Sarah Hacklex

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331X Respiratory Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intra-Cranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-9, 19 57, to 9-14, 19 57, that I last saw the deceased alive on 9-14, 19 57, and that death occurred at 1:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. ADDRESS (Street, city or town, state): 5301 Hamilton Ave., Hyattsville DATE SIGNED: 9/15/57

PHYSICIAN'S NAME (Type): John W Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10/11/57

22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital

22d. LOCATION (City, town, or county) (State): Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator — ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 16 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

20773782V2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09802

9794 Item 7 FilmG220 9-19-57 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS: 5325 Southern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Albert; Middle: ; Last: Jardine

4. DATE OF DEATH: Month: September; Day: 15; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Married)

8. DATE OF BIRTH: June 24, 1902

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph R. Smith — Address: 2309 Sheridan Street, West Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 15, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9-17-57
22c. NAME OF CEMETERY OR CREMATORY: Lees' Crematorium.
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lee Funeral Home - 300 4th St. N.E. D.C.

24a. REC'D BY REGISTRAR DATE: SEP 17 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09803

9795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Berwyn Heights
d. STREET ADDRESS: 8801 53rd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: Taney — Last: Jones
4. DATE OF DEATH: Month: Sept. — Day: 6, — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11- - 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired merchant
10b. KIND OF BUSINESS OR INDUSTRY: Automobile tires
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Georges Francis Jones
14. MOTHER'S MAIDEN NAME: Ida Virginia Kessler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Carlton T. Jones ; same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH
903.0
DUE TO (b): Fractured humerus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Fall in bathtub

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiovascular renal disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall in bathtub while taking a bath.
20c. TIME OF INJURY: 3.00 ☒ a.m. ☐ p.m. — Month, Day, Year: 8-31-57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Berwyn Hts. Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D. — DATE SIGNED
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ — 9-6-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9/9/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons — ADDRESS: 4739 Balto. Ave. Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 9 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9841

CERTIFICATE OF DEATH

09804
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ammendale
c. LENGTH OF STAY IN 1b: 14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ammendale Normal Institute

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Ammendale--Beltsville P.O.
d. STREET ADDRESS: Ammendale Normal Institute
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Brother Ezear Alfred Middle (Bernard) Last Kelly
4. DATE OF DEATH: Month Sept. Day 25th, Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Christian Brother
10b. KIND OF BUSINESS OR INDUSTRY: Religious Order
11. BIRTHPLACE (State or foreign country): Phila. Penna.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Brother Anselm, Ammendale Normal Institut

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.0
DUE TO (b): Arteriosclerotic Heart — 15 Yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Gen'l. Arteriosclerosis — 20 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-1944, 19____, to 9-24-57, 19____, that I last saw the deceased alive on 9-17-57, 19____, and that death occurred at 2 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. M. Warren M.D. ADDRESS (Street, city or town, state): Laurel Md DATE SIGNED: 9-25-57
PHYSICIAN'S NAME (Type): J. M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/28/1957
22c. NAME OF CEMETERY OR CREMATORY: Private Cemetery Ammendale Normal Institute
22d. LOCATION (City, town, or county) (State): Beltsville, P.O.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.W.Chambers Company, Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: SEP 30 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9796 — 09805 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Daytona Beach 48x-3
d. STREET ADDRESS: 533 Palmetto
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: — Last: Kisseleff
4. DATE OF DEATH: Month: September — Day: 23 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 22, 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Kisseleff
14. MOTHER'S MAIDEN NAME: Luba Botkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Ruth Ladd, Address: 3374 Oak Glen Way S.E. Washington 28, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular renal disease
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): James I. Boyd
DATE SIGNED: September 23, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/25/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bernard Danzansky & Sons 3501 14th St., N.W.
24a. REC'D BY REGISTRAR — DATE: SEP 27 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,12,13,14 FilmC220 9-24-57 et

9797 **CERTIFICATE OF DEATH** 09806

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 105 days
d. NAME OF HOSPITAL OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6906-22 Pl., W. Hyattsville, Md. 16
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nicholas Middle C. Lost Koutsoukos

4. DATE OF DEATH: Month 9 Day 2 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-6-78

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Corinth, Greece

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chis N. Koutsoukos

14. MOTHER'S MAIDEN NAME: Sophia (Surname unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	2 WEEKS
DUE TO (b)	CHRONIC GLOMERONEPHRITIS	2 MONTHS
DUE TO (c)	GENERALIZED ARTERIOSCLEROSIS	3 MONTHS

446X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260X FRACTURE OF PELVIS + DIABETES

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-21, 1957, to 9-2-, 1957, that I last saw the deceased alive on 9-2, 1957, and that death occurred at 1:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D. ADDRESS (Street, city or town, state): 4300 KAYWOOD Dr DATE SIGNED

PHYSICIAN'S NAME (Type): SAMUEL J. N. SUGAR MD MT. RAINIER Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-5-57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

22d. LOCATION (City, town, or county) (State): Cottage City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee Funeral Home, 4th & Mass. Ave., N. E., Wash.

24a. REC'D BY REGISTRAR DATE: SEP 4 '57

24b. REGISTRAR'S SIGNATURE: W. Creech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09807

Reg. Dist. No. 245

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale, Maryland
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 College Park, Maryland.
d. STREET ADDRESS: 8901 48th avenue,.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Barbara — Last: Kulp

4. DATE OF DEATH: Month: September — Day: 14, — Year: 19 57.

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 24, 1897

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Marysville, Ohio

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Michael Worelin

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Darlington Kulp — Address: College Park, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Crushed chest
DUE TO (c): Automobile accident

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in an automobile in collision with another car.

20c. TIME OF INJURY: Hour 10.01 a. m. — Month, Day, Year: 9-14- 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Beltsville (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney, M.D.

EXAMINER'S NAME (Type): John T. Maloney, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Sept. 14, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/18/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F; Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: SEP 19 1957

24b. REGISTRAR'S SIGNATURE: James Leary

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be obtained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15ME
2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG220 9-16-57 et

9842

CERTIFICATE OF DEATH

09808

Reg. Dist. No. 245

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEWISDALE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Private home - 2401 Drexel Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 HYATTSVILLE
d. STREET ADDRESS: 2401 Drexel Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elaine; Middle: C.; Last: LeNoir

4. DATE OF DEATH: Month: September; Day: 4; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 3; Days: 29
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GERALD P. LeNOIR

14. MOTHER'S MAIDEN NAME: KATHRYN A. COINER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Hyattsville, Md.
Gerald P. LeNoir 2401 Drexel St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory failure — INTERVAL BETWEEN ONSET AND DEATH:
475 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Upper respiratory infection — 72 hours
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Microcephaly, convulsions, generalized

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 5, 1957, 19____, to September 4, 1957, that I last saw the deceased alive on September 3, 1957, and that death occurred at 8:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Stanley H. Steinberg, M.D. — ADDRESS (Street, city or town, state): 5223 South Dakota Avenue, N. E. — DATE SIGNED: 9/4/57

PHYSICIAN'S NAME (Type): Stanley H. Steinberg, M. D. — Washington 11, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-6-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: F. J. Collins — ADDRESS: Francis J. Collins 3821 14th. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: Sept. 6 1957

24b. REGISTRAR'S SIGNATURE: Mrs Jas. Levere Deputy

9 V V V V V V X V V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9799

09809 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Edmonston
d. STREET ADDRESS: 5208 Decatur Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Williard — Last: Limerick

4. DATE OF DEATH: Month: Sept. — Day: 15. — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-14-05

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Limerick
14. MOTHER'S MAIDEN NAME: Nanie Butcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Harry W. Limerick, Jr; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular renal disease — INTERVAL BETWEEN ONSET AND DEATH:
442X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 16, 1957
EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/18/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR — DATE: SEP 19 '57
24b. REGISTRAR'S SIGNATURE

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9800 — 09810 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GENERAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 MARYLAND PARK
d. STREET ADDRESS: 6410 E ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: E — Last: LITTLE

4. DATE OF DEATH: Month: SEPT. — Day: 10 — Year: 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-15-56

9. AGE (In years last birthday): 9 mos. yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles E Little

14. MOTHER'S MAIDEN NAME: Mary Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Charles E. Little — Address: Maryland Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock and electrolyte imbalance — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

571.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Diarrhea and dehydration — 1 week

DUE TO

(c) Enteritis (causative organism undetermined) — 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/10, 1957, to 9/10, 1957, that I last saw the deceased alive on 9-10, 1957, and that death occurred at 3/45A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Max M. Harzberg M.D. — ADDRESS (Street, city or town, state): 7016 Grey St., Seat Pleasant Md. — DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/13/57 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville Md. — 24a. REC'D BY REGISTRAR DATE: SEP 16 57 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9845 — 09811 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY: Prince George's — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville	c. LENGTH OF STAY IN 1b: 12 years
	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Forestville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 262 Flowers Lane	d. STREET ADDRESS: 262 Flowers Lane — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Henry	Littleton	9	11	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Colored		1/11/82	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	general	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Oscar Littleton	Jennie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Rosa Littleton — Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis	
442X DUE TO (b)	Cardiovascular renal disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 9/11/57

EXAMINER'S NAME (Type): James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-14-57	Lincoln Memorial	Suitland MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Myrtle K. Collins 4339 Hunt Pl., N.E., D.C.	SEP 17 1957	Carrie Campbell

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9801

CERTIFICATE OF DEATH

09812 245

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 6440 Rollins Ave., Seat Pleasant, Maryland
d. STREET ADDRESS: 6440 Rollins Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar; Middle: Walker; Lost: Lynch

4. DATE OF DEATH: Month: Sept.; Day: 20; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1897

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed (2 yrs)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Walker Lynch

14. MOTHER'S MAIDEN NAME: Augusta Petigust

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Helen McLynch Address: Seat Pleasant Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cirrhosis of Liver	2 yrs
581.0 DUE TO	Abdominal Ascites	1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Congestive Heart Failure	2 yrs
(c)	Arteriosclerotic Heart Dis.	2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Sept 20, 1957, that I last saw the deceased alive on Sept 20, 1957, and that death occurred at 12 30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L W Malin M.D. ADDRESS (Street, city or town, state): Riverdale, Md DATE SIGNED: 9-18-57

PHYSICIAN'S NAME (Type): L W Malin M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/23/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Lanham Md

23. FUNERAL DIRECTOR'S SIGNATURE: T Rosales Son ADDRESS: Hyattsville Md

24a. REC'D BY REGISTRAR DATE: SEP 25 1957

24b. REGISTRAR'S SIGNATURE: James Devereux

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9802 — Reg. Dist. No. 09813

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN this city: 17yrs. 17da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LAUREL SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: BALTIMORE CITY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CATONSVILLE 3VO 1-4
d. STREET ADDRESS: 449 AGUSTA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lilly — Middle: M. — Last: MACKERT
4. DATE OF DEATH: Month: SEPT. — Day: 9 — Year: 1957

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 16, 1867
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM STEINWEDEL
14. MOTHER'S MAIDEN NAME: CHRISTINA NEEB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: HENRY MACKERT — Address: SAME (HUSBAND)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypostatic Congestion	48 hrs.
DUE TO (b)	Chronic Endocarditis	Several yrs
DUE TO (c)	General Arteriosclerosis	20 yrs.

421.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 24, 1940 to Sept 9, 1957 that I last saw the deceased alive on Sept 8, 1957, and that death occurred at 11:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jesse C. Coggins M.D. — ADDRESS (Street, city or town, state): LAUREL SANITARIUM — DATE SIGNED:
PHYSICIAN'S NAME (Type): JESSE C. COGGINS — LAUREL - MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/12/57
22c. NAME OF CEMETERY OR CREMATORY: Fondon Park
22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: MacNabb + Son — ADDRESS: 28
24a. REC'D BY REGISTRAR — DATE: SEP 11 '57
24b. REGISTRAR'S SIGNATURE: W. Kreuch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9754 CERTIFICATE OF DEATH

Reg. Dist. No. 09814 345

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5604 Hamilton Manor Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 5604 - Hamilton Manor Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Edgar Middle C. Lost Marshall
4. DATE OF DEATH: Month Sept Day 12 Year 1957

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 4,1883
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. P.E.P. Co.
10b. KIND OF BUSINESS OR INDUSTRY: Engineer
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Marshall
14. MOTHER'S MAIDEN NAME: Jennie ———

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 577-05-0015A
17. INFORMANT: Mrs Bessie Marshall — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	2 weeks
DUE TO	420.1	
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (b)	Coronary Arteriosclerosis	2 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1956, to Sept 12, 1957, that I last saw the deceased alive an September 11, 1957, and that death accurred at 7:15 A.M., from the causes and on the date stated abave.

ACTUAL SIGNATURE: Arnold A. Lear M.D.
ADDRESS (Street, city or town, state): 905 Sheridan Street
DATE SIGNED: 9-12-57

PHYSICIAN'S NAME (Type): Arnold A. Lear, M. D.
Hyattsville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-16-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — 300 -4th St N.E Wash, D.C.
ADDRESS
24a. REC'D BY REGISTRAR DATE: SEP 13 1957
24b. REGISTRAR'S SIGNATURE: James Devery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09815

9803 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

M 99 I 1 0 V 2 2

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Office of Bryan Warren, M.D.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 13xo.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joan — Middle: Louise Elizabeth — Last: Miles

4. DATE OF DEATH: Month: September — Day: 11, — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 24, 1955

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Schaffer

14. MOTHER'S MAIDEN NAME: Mary Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mary Miles; same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diffuse bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
491x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that deoth resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE: John J. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 11, 1957

EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 13/57
22c. NAME OF CEMETERY OR CREMATORY: Blacon Chapel
22d. LOCATION (City, town, or county) (State): Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgely Selby
ADDRESS: 401 Washington Laurel Md

24a. REC'D BY REGISTRAR — DATE: SEP 16 '57
24b. REGISTRAR'S SIGNATURE: W. H. Leach

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9804

09816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 Hr 30Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Seabrook
d. STREET ADDRESS: 6403 94th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle — Last: Miller

4. DATE OF DEATH: Month: Sept — Day: 5 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 5, 57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 1 — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Windom Carlton Miller

14. MOTHER'S MAIDEN NAME: Doris Jean Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother. Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 761.5
DUE TO (b): Prematurity, 2 Months Premature
DUE TO (c): Separation of Placenta & Prolapsed Cord

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/5/57, 19____, to 9/5/57, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J M Warren M.D. ADDRESS (Street, city or town, state): Laurel, Md. DATE SIGNED: 9/5/57

PHYSICIAN'S NAME (Type): John M. Warren

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 7-1957

22c. NAME OF CEMETERY OR CREMATORY: Elliott's Chapel

22d. LOCATION (City, town, or county) (State): Fort Meade, Anne Arundel Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Richardson ADDRESS: Laurel Md.

24a. REC'D BY REGISTRAR DATE: SEP 10 57

24b. REGISTRAR'S SIGNATURE: [illegible]

2077335XV1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9844

09817

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): At Dr. James Sasscer's Office

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McLean 83x-3
d. STREET ADDRESS: Route # 3, Box 328
e. IS RESIDENCE ON A FARM? YES [x] NO [ ]

3. NAME OF DECEASED (Type or print)
First: Clifton Middle: George Last: Muns

4. DATE OF DEATH Month: September Day: 15 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 15, 1917

9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Muns

14. MOTHER'S MAIDEN NAME: Ollie Strate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. II

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs Gwendolyn Muns, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis

420.1

DUE TO (b) Cardiovascular renal disease

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [x], Inquiry [x] and find that death resulted from: Natural causes [x], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [x]

EXAMINER'S NAME (Type): James I. Boyd

DATE SIGNED: September 15, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/18/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town or county): Arlington (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Sons ADDRESS: 4739 B. of Ave Hgts.

24a. REC'D BY REGISTRAR DATE: SEP 17 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

VS. A15ME(5)
5M 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9805

Reg. Dist. No. 09818

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 40 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: PG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md. 15
d. STREET ADDRESS: 1409 East West Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: — Last: Myers

4. DATE OF DEATH: Month: Sept — Day: 19 — Year: 1957

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED ☒	Sept 17 1886	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Representative	U.S. Gov't.	Washington, D.C.	U.S.A.

13. FATHER'S NAME: Ellis Myers

14. MOTHER'S MAIDEN NAME: Mary Franzoni

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Aranella Myers — Address: Same as above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	40mins
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	4weeks
DUE TO (c)	Coronary Thrombosis	16mos.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1956 to Sept. 19, 1957, that I last saw the deceased alive on Sept. 19, 1957, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. C. Hageage, M.D. — ADDRESS (Street, city or town, state): 3308 Perry St. Mt. Rainier, Md. — DATE SIGNED: 9/20/57

PHYSICIAN'S NAME (Type): Dr. C Hageage — 3308 Perry St. Mt. Rainier, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/23/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc. — ADDRESS: 3200 Rhode Island Ave. Mt. Rainier, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 23 '57

24b. REGISTRAR'S SIGNATURE: W. Leech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9845

CERTIFICATE OF DEATH

JOSEPH NEIMARICH 09819

Reg. Dist. No.

Item 3: G 221 10/2/57 L

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kuirl - Bellsville
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION: Saint Barnich Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE 1526.2
d. STREET ADDRESS: 12804 Weiss St. R
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Peter Joseph — Middle — Last Nemarich Neimarich

4. DATE OF DEATH: Month Sept. — Day 28 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 28, 1893
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembler
10b. KIND OF BUSINESS OR INDUSTRY: Auto. Industry
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Simon Nemarich
14. MOTHER'S MAIDEN NAME: Anna Fesac

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Nursing Home Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive failure - cardiac — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO
153x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized carcinomatosis of pituitary 2 yrs.
DUE TO
(c): ca Carcinoma of colon.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Sept, 1957, that I last saw the deceased alive on 28 Sept 1957, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest E Harmon M.D.
ADDRESS (Street, city or town, state): 9301 Colesville Rd. Silver Spring, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): ERNEST E. HARMON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: OCT 1, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county): Washington (State): D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 Carroll St. N.W. D.C.
24a. REC'D BY REGISTRAR DATE: SEP 30 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

RECEIVED

SEP 30 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9846 — Reg. Dist. No. 19820

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6394 Walker Mill Rd SE

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Oakland
d. STREET ADDRESS: 6394 Walker Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: Nichols

4. DATE OF DEATH: Month: Sept — Day: 26 — Year: 1957

5. SEX: Male — 6. COLOR OR RACE: Colored — 7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: July 21, 1899 — 9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: General — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Thomas Nichols — 14. MOTHER'S MAIDEN NAME: Rachel Mullins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: 577160941 — 17. INFORMANT: Estelle C. Tilghman — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH

442X

DUE TO (b): Cardiovascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James I. Boyd M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: Sept 26, 1957

EXAMINER'S NAME (Type): JAMES I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9-30-57 — 22c. NAME OF CEMETERY OR CREMATORY — 22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Alexander Ford Jr. — ADDRESS: 414-15 S.E. WASH., D.C. — 24a. REC'D BY REGISTRAR DATE: SEP 30 '57 — 24b. REGISTRAR'S SIGNATURE: W. Sedwick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09821

9755

Reg. Dist. No. 345

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2419 Lewisdale Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 1 2419 Lewisdale drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

00 M

3. NAME OF DECEASED (Type or print): First: Carl; Middle: ; Last: Oksanen

4. DATE OF DEATH: Month: September; Day: 25; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired truck driver

10b. KIND OF BUSINESS OR INDUSTRY: City of Duluth, Minn.

11. BIRTHPLACE (State or foreign country): Finland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otto Oksanen

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Arena; same address.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxemia
570.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intestinal obstruction
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 25, 1957

EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/27/57
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
22d. LOCATION (City, town, or county) (State): Silver Springs, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: SEP 30 1957

24b. REGISTRAR'S SIGNATURE: James Devaney

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9806

Reg. Dist. No. 09822 248

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 15.26.2
d. STREET ADDRESS: 204 Adams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle Edgar — Last Peddicord, Jr.
4. DATE OF DEATH: Month September — Day 7 — Year 1957
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 17, 1921
9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dist. of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Edgar Peddicord
14. MOTHER'S MAIDEN NAME: Lucille Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mother; Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock
823X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Fractured skull
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with a bridge.
20c. TIME OF INJURY — Hour 5.45 p.m. — Month, Day, Year 9-7-1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Beltsville (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 7, 1957
EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/10/57
22c. NAME OF CEMETERY OR CREMATORY: Darnestown Church Cem.
22d. LOCATION (City, town, or county) (State): Darnestown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 10 1957
24b. REGISTRAR'S SIGNATURE: James Lowery

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09823

· 9807 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Naylor
d. STREET ADDRESS: Box C 87
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara; Middle:; Last: Pinkney

4. DATE OF DEATH: Month: September; Day: 11; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-6-92

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard Skinner

14. MOTHER'S MAIDEN NAME: Elizabeth Spence

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph Pinkney
Address: Box 87 C Naylor, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Heart Disease — 1 year
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gen. Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-24, 1957, to 9-11-, 1957, that I last saw the deceased alive on 9-11-, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D.
ADDRESS (Street, city or town, state): 4300 Raywood Dr
DATE SIGNED: 9/12/57
PHYSICIAN'S NAME (Type): SAMUEL J. N. SUGAR MD MT RAINIER MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-14-57
22c. NAME OF CEMETERY OR ~~CREMATORY~~: Brooks Church
22d. LOCATION (City, town, or county) (State): Naylor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Myrtle R. Rollins
ADDRESS: 4339 Hunt Pl., N.E. 19, D.C.

24a. RECEIVED BY REGISTRAR DATE: SEP 2 1957
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9808 Items 7,9 FilmG221 10-10-57 et

09824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 85 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Hyattsville
d. STREET ADDRESS: 4221 Oglethorpe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: — Last: Proctor

4. DATE OF DEATH: Month: Sept. — Day: 30 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 June 1904

9. AGE (In years last birthday): 5253 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Edward B Simonds

14. MOTHER'S MAIDEN NAME: Delia E. Laster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: C. Oliver Proctor — Address: Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 wks
175X
DUE TO
(b): CARCINOMA of Ovary — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1, 1955, to 9/30, 1957, that I last saw the deceased alive on 9/30, 1957, and that death occurred at 5.30 AM. from the causes and on the date stated above.

ACTUAL SIGNATURE: A Deitz M.D. — ADDRESS (Street, city or town, state): Hyattsville, Md — DATE SIGNED: 9-30-57

PHYSICIAN'S NAME (Type): Dr. A. Deitz

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/2/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville Maryland.

24a. REC'D BY REGISTRAR — DATE: OCT 4 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) REM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9809

09825

CERTIFICATE OF DEATH

Item 7. Film G220. 9/26/57 rcv

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Mt. Rainier
d. STREET ADDRESS: 3803 35th St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Guy — Middle: W — Last: Richards

4. DATE OF DEATH: Month: Sept — Day: 18 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-18-77

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture Dept Gov't

11. BIRTHPLACE (State or foreign country): Md -

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Richards

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Isabelle Underwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Sarah E. Nichols — Address: Washington D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Seminoma of the Testicle — 10 years
DUE TO (c): —

178X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 31, 19 57, to Sept 18, 19 57, that I last saw the deceased alive on Sept 18, 19 57, and that death occurred at 10:25 A.M., P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. Sugar M.D.

ADDRESS (Street, city or town, state): 4300 Raywood Drive Mt. Rainier, Md.

DATE SIGNED: 9/19/57

PHYSICIAN'S NAME (Type): Samuel J. Sugar, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/21/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: SEP 23 '57

24b. REGISTRAR'S SIGNATURE: [signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09826

CERTIFICATE OF DEATH

9847

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland
c. LENGTH OF STAY IN 1b 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4450 Whitehall Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Seat Pleasant
d. STREET ADDRESS 17004 Griep Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Bessie Middle E. Last RIEGER

4. DATE OF DEATH Month Sept. Day 16, Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 8/23/78
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S. of A.

13. FATHER'S NAME Albert Sylvester Frazier
14. MOTHER'S MAIDEN NAME Hanna Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mrs. R. S. Tryon, 7004 Griep St, Seat Pleasant.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — ? years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arthritis, rheumatoid, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) — (County) — (State) —

21. I certify that I attended the deceased from Sept. 25, 1956 to Sept. 16, 1957 that I last saw the deceased alive on Sept. 15, 1957, and that death occurred at 12:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Walcutt W. Gibson M.D. ADDRESS (Street, city or town, state) 2412 Minnesota Avenue, S.E. DATE SIGNED

PHYSICIAN'S NAME (Type) Walcutt W. Gibson Washington 20, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 9/19/57
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR DATE SEP 17 1957
24b. REGISTRAR'S SIGNATURE Carrie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09827

9810 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: adm. 7-19-57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LAUREL SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47x-3
d. STREET ADDRESS: KENESAW Apt. 16th & Irving Sts. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BESSIE — Middle CARTER — Last RILEY

4. DATE OF DEATH: Month September — Day 26 — Year 1957

5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-6-1867
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months 4 — Days 20
IF UNDER 24 HRS.: Hours — — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN GRAYSON CARTER
14. MOTHER'S MAIDEN NAME: SUSAN FITZHUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Address: Hospital Records, Laurel Sanitarium

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): VENTRICULAR Fibrillation — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO (b): arteriosclerotic cardio-vascular disease — many years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chronic Brain syndrome associated with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 —
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-19- 1957, to 9-26- 1957, that I last saw the deceased alive on 9-25- 1957, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Erika P. Kraemer M.D. — ADDRESS (Street, city or town, state): Laurel Sanitarium Laurel — DATE SIGNED: 9-26-57

PHYSICIAN'S NAME (Type): ERIKA P. KRAEMER — Laurel Sanitarium Laurel Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 28/57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Martin W. Hysong Co. — ADDRESS: 1300 N St. N.W, DC

24a. REC'D BY REGISTRAR DATE: SEP 27 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9811 CERTIFICATE OF DEATH

Reg. Dist. No. 09828

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
c. LENGTH OF STAY IN 1b: 26 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Inwood Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg 33
d. STREET ADDRESS: INWOOD STREET.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARRIE Middle — Last Ringold

4. DATE OF DEATH: Month Sept. Day 4 Year 1957

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 1, 1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jack Harris

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Charles H. Washington — Address: Bladensburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 month

592 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Nephritis with Hypertension — 4-5 yrs
DUE TO (c): Chronic Vascular disease — 5-10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m., 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 5, 1957, to Sept. 4, 1957, that I last saw the deceased alive on Sept. 2, 1957, and that death occurred at 4:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. W. Spiller M.D. — ADDRESS (Street, city or town, state): 4506 R. I. Ave. Brentwood Md — DATE SIGNED: 9-4-57

PHYSICIAN'S NAME (Type): W. W. Spiller — Brentwood, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-7-57

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn

22d. LOCATION (City, town, or county) (State): Benning Rd SE DC

23. FUNERAL DIRECTOR'S SIGNATURE: Henry L. Washington — ADDRESS: 467 N St NW

24a. REC'D BY REGISTRAR DATE: SEP 9 1957

24b. REGISTRAR'S SIGNATURE: I. W. Reddick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9848

CERTIFICATE OF DEATH

09829
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf, Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf, Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Marvin — Last: Roby Sr.
4. DATE OF DEATH: Month: Sept. — Day: 5 — Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 11 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Charles Co, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Theodore Roby
14. MOTHER'S MAIDEN NAME: Mary Emma Downs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-36-3817
17. INFORMANT — Address: Mrs. Gladys Roby, Waldorf, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Apoplexy — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hypertension
DUE TO (c): Aortic Valvular Dis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1940 to Sept 5, 1957, that I last saw the deceased alive on 9-4, 1957, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Waldorf MD — DATE SIGNED:
PHYSICIAN'S NAME (Type): GEORGE S WEBER M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: St. Pauls
22d. LOCATION (City, town, or county) (State): Waldorf Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hunt Funeral Home Waldorf, Md.
24a. REC'D BY REGISTRAR — DATE: SEP 10 '57
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9812 CERTIFICATE OF DEATH

Reg. Dist. No. 11074

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Bowie
d. STREET ADDRESS 1109 - Chester Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Baby Middle Girl Lost Savoy

4. DATE OF DEATH Month Sept. Day 10 Year 1957

5. SEX Female
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-10-57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas LeRoy Harrison
14. MOTHER'S MAIDEN NAME Mary Delores Savoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mother Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity (2050 gms. 16 inches)
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 10, 1957, to Sept 10, 1957, that I last saw the deceased alive on Sept 10, 1957, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John W. Perkins M.D. ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md. DATE SIGNED 9/11/57

PHYSICIAN'S NAME (Type) John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 10/11/57
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital
22d. LOCATION (City, town, or county) (State) Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator. ADDRESS
24a. REC'D BY REGISTRAR DATE OCT 16 '57
24b. REGISTRAR'S SIGNATURE

2077/61XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9813 CERTIFICATE OF DEATH

Reg. Dist. No. 11077

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 33 Bladensburg, Maryland
d. STREET ADDRESS: 1 Box 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Baby — Middle Boy — Last Sharpe

4. DATE OF DEATH: Month Sept — Day 13 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 13 1957

9. AGE (In years last birthday): 2Hrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elijah Washington

14. MOTHER'S MAIDEN NAME: Geraldine Sharpe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity (1050 gms. 13 inches) — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 13, 1957 to Sept 13 1957 that I last saw the deceased alive on Sept. 13, 1957, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins, M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyattsville — DATE SIGNED: 9/14/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10/11/57
22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital
22d. LOCATION (City, town, or county) (State): Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry C. Penn, Jr. Administrator — ADDRESS

24a. REC'D BY REGISTRAR DATE: OCT 16 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2077202 XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09830

9849 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH
a. COUNTY: Prince Georges' — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forestville
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7501 Marlboro Pike, S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges'
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Forestville
d. STREET ADDRESS: 7501 Marlboro Pike, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Flossie — Middle: May — Last: Simmons

4. DATE OF DEATH: Month: September — Day: 17 — Year: 19 57.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Tenent
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David Hurt
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: -----
17. INFORMANT — Address: Helen Stamp- same as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
442x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b) Cardiosclerosis, Hypertension — Unknown
DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Nonspecific Colitis 6 MO
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): — Natural Causes
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 22, 19 57, to Sept 17, 19 57, that I last saw the deceased alive on Aug 16, 19 57, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul C Van Natta M.D. — ADDRESS (Street, city or town, state): 5420 Silver Hill Rd S.E. — DATE SIGNED: 9/17/57
PHYSICIAN'S NAME (Type): PAUL C VAN NATTA MD — Washington 28 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/57
22c. NAME OF CEMETERY OR CREMATORY: Addison's Chapel Cem:
22d. LOCATION (City, town, or county) (State): Seat Pleasant, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Upper
Ritchie Bros. Funeral Home-Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: SEP 02 1957
24b. REGISTRAR'S SIGNATURE: Carrie Campbell

EJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09831

9814 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 Hr 20Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine X2
d. STREET ADDRESS: Rt 2 Box 302 A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle: ; Last: Simms

4. DATE OF DEATH: Month: Sept; Day: 4; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4, 57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: 1; Min.: 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James M. Simms

14. MOTHER'S MAIDEN NAME: Virginia A. Locks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fetal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH:
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Prematurity (weight 700 gms. length 12 inches)
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/4/ 19 57 to 9/4/ 19 57 that I last saw the deceased alive on 9/4/ 19 57, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St., Hyatts. Md — DATE SIGNED: 9/6/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Sept 1957

22c. NAME OF CEMETERY OR CREMATORY: Prince Georges

22d. LOCATION (City, town, or county) (State): Glen Forge Cheverly Md

23. FUNERAL DIRECTOR'S SIGNATURE: Henry N. Pennyfeather Adm — ADDRESS:

24a. RECD BY REGISTRAR DATE: SEP 18 57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

207728 9XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09832

9815 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 4408-Garrison St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John Middle: A Last: Stanton

4. DATE OF DEATH: Month: Sept. Day: 12 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: June 22 1874

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kynotype

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gererment

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: John

14. MOTHER'S MAIDEN NAME: Sophia Benjamin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT (Address): Claude Stanton-6803-Fairfax Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/4/55 to 9/11/57, that I last saw the deceased alive on 9/11/57, and that death occurred at 9:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frederick E. Munier M.D.
ADDRESS (Street, city or town, state): 2409 Varnum St
DATE SIGNED: 9/11/57
PHYSICIAN'S NAME (Type): Landover Hills, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 15, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d. LOCATION (City, town, or county) (State): Bladensburg Rd. Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. CHAMBERS
ADDRESS: Co 3072 M St N.W.

24a. REC'D BY REGISTRAR DATE: SEP 19 57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9816

CERTIFICATE OF DEATH

09833
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7805 Halleck Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bonnie; Middle:; Last: Stottlemire

4. DATE OF DEATH: Month: September; Day: 26; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/7/53

9. AGE (In years last birthday): 4 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lloyd Stottlemire

14. MOTHER'S MAIDEN NAME: Edith Life

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Edith Life 7805 Halleck St. Dist Hts. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
292.4
DUE TO
(b): Pancytopenia — 1 month
DUE TO
(c): Aplastic Anemia — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/29, 1957, to 9/26, 1957, that I last saw the deceased alive on 9/26, 1957, and that death occurred at 6.05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John T. Lupo M.D. ADDRESS (Street, city or town, state): 5241 St. Barnabas Rd DATE SIGNED: 9/27/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-30-57

22c. NAME OF CEMETERY OR CREMATORY: Natl. Mem. Park

22d. LOCATION (City, town, or county) (State): Falls Church, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: OCT 1 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9817

09834
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges' — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 15 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Prince Georges' General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges'
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-Upper Marlboro X/
d. STREET ADDRESS: Rt. #2, Box 98
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Franklin — Middle: A. — Last: Sweeney

4. DATE OF DEATH: Month: September — Day: 9, — Year: 1957.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 8, 1900

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Emplyd Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: County Comm.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Greenberry Sweeney

14. MOTHER'S MAIDEN NAME: Nettie Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lorraine Virgin- Address same as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ~~Homorrhage and shock~~
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ~~Fracture of the base of the skull~~
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
car
~~Driver of an automobile that was struck by another~~

20c. TIME OF INJURY: Hour 7:20 a.m. — Month, Day, Year: 9/9/ 19 57

20d. INJURY OCCURRED: While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route # 301 — 20f. (City or town): Upper Marlboro — (County): P. G. — (State): Md.

21. I certify that I taak charge of the remains described abave, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Hamicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 9/10/57:

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/13/57
22c. NAME OF CEMETERY OR CREMATORY: Epiphany Cemetery
22d. LOCATION (City, town, or county): Forestville, (State): Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ritchie Bros. Upper Marlboro, Md.

24a. REC'D BY REGISTRAR DATE: SEP 16 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9818 CERTIFICATE OF DEATH

Reg. Dist. No. 09835

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md
d. STREET ADDRESS: 7112 Annapolis Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Sweeney Last

4. DATE OF DEATH: Month Sept Day 4 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB 9th 1905

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT LESTER SWEENEY

14. MOTHER'S MAIDEN NAME: MARY MARGARET SWEENEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MRS. RUTH SWEENEY Address: 7112 ANNAPOLIS RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Lower Lip with metastases — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
140X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Jul, 1957, to 4 Sept, 1957, that I last saw the deceased alive on 3 Sept, 1957, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Maloney M.D. ADDRESS (Street, city or town, State): 4814-71st Ave. Landover Hills Md DATE SIGNED: 4 Sept 57

PHYSICIAN'S NAME (Type): Dr. T. Maloney

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-8-57

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet

22d. LOCATION (City, town, or county) (State): Wash. D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Moulon ADDRESS: 3531-GA Ave N.W.

24a. REC'D BY REGISTRAR DATE: SEP 9 '57

24b. REGISTRAR'S SIGNATURE: W. H. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9819 **CERTIFICATE OF DEATH** Reg. Dist. No. 09836

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 hrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Oakcrest
d. STREET ADDRESS: Rt. 2 Box 140
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Taylor

4. DATE OF DEATH: Month: Sept. — Day: 3 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3 Sept. 1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: x4 — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Frank Taylor, Jr.

14. MOTHER'S MAIDEN NAME: Mary Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

776x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Sept 3, 1957 to Sept 3, 1957 that I last saw the deceased alive on Sept 3, 1957, and that death occurred at 4,40 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank L. Weaver Jr. M.D. — ADDRESS (Street, city or town, state): 320 Montgomery Laurel, Md — DATE SIGNED: 9/4/57

PHYSICIAN'S NAME (Type): Frank L. Weaver, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — **22b. DATE THEREOF**: Sept 1957 — **22c. NAME OF CEMETERY OR CREMATORY**: Prince Georges Memorial Park — **22d. LOCATION** (City, town, or county) (State): Cheverly Md

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Penn — **ADDRESS**: Cedar

24a. REC'D BY REGISTRAR DATE SEP 18 '57 — **24b. REGISTRAR'S SIGNATURE**: [illegible]

2077/236x40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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16

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9820

09837

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 24 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York 69x.3
d. STREET ADDRESS: 248 W. 133rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Frances — Last: Taylor

4. DATE OF DEATH: Month: Sept. — Day: 4th, — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: XXXXX 5-31-09

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.c.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Taylor

14. MOTHER'S MAIDEN NAME: Ella F. Gause

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary C. Doublin, Address: 4400 Douglas St., N.E. Wash. D.C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral compression — INTERVAL BETWEEN ONSET AND DEATH:
816X
DUE TO
(b): Subdural Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Riding as a passenger in an automobile in collision with another.

20c. TIME OF INJURY: Hour: 6.30 XXX — Month, Day, Year: 9-3- 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Landover, Pr. Geo. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 5, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/9/57
22c. NAME OF CEMETERY OR CREMATORY: Paynes
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Howard
ADDRESS: 30 H Street, N.E.

24a. REC'D BY REGISTRAR DATE: SEP 9 '57
24b. REGISTRAR'S SIGNATURE: Quesenberry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9821 CERTIFICATE OF DEATH

Reg. Dist. No. 0983845

1. PLACE OF DEATH
a. COUNTY: PR Geo — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 4yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4705 Longfellow St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4705 Longfellow St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle LOUISE Last THOMPSON
4. DATE OF DEATH: Month Sept Day 23 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 23 - 1897
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Milliner
10b. KIND OF BUSINESS OR INDUSTRY: Textile
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wm Rutherford
14. MOTHER'S MAIDEN NAME: Mary Ann Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gertrude [illegible] Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
580X
DUE TO (b): Acute Hepatic Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-21 19 57 to 9-23 19 57 that I last saw the deceased alive on 9-23 19 57, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W L Etienne M.D.
ADDRESS (Street, city or town, state): 4713 Kenwyn Rd College Park, Md.
DATE SIGNED: 9-23-57
PHYSICIAN'S NAME (Type): W. L. ETIENNE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
22d. LOCATION (City, town, or county) (State): Bladensburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville Md.
24a. REC'D BY REGISTRAR DATE: SEP 25 1957
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9850 **CERTIFICATE OF DEATH** Reg. Dist. No. 09839 147

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland
c. LENGTH OF STAY IN 1b 6 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201- Swann Rd SE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Suitland
d. STREET ADDRESS 1201- Swann Rd SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mabel Middle E. Lost Thompson

4. DATE OF DEATH Month Sept. Day 18 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH MAR. 25- 1886
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William Ellis
14. MOTHER'S MAIDEN NAME Agnes Packham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Eileen T. Gardner Address 301- Swann Rd SE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH approx 2 hrs.

DUE TO (b) Hypertensive Cardiovascular disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 1952, to Sept. 18, 1957, that I last saw the deceased alive on Sept 10, 1957, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Cornelius P. Frey, M.D. ADDRESS (Street, city or town, state) 1625 Mass. Ave. NW. Wash., D.C. DATE SIGNED

PHYSICIAN'S NAME (Type) Cornelius P. Frey, Sept 18, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept 20-57
22c. NAME OF CEMETERY OR CREMATORY Interment
22d. LOCATION (City, town, or county) (State) Washington D C

23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros ADDRESS 1661- Good Hope Rd S E Wash D C
24a. REC'D BY REGISTRAR DATE SEP 19 1957
24b. REGISTRAR'S SIGNATURE Annie Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9851

09840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANDOVER KNOLLS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 6505 - OTIS ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3
d. STREET ADDRESS: 1405 E. CAPITAL ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAULINE Middle A. Last THOMPSON

4. DATE OF DEATH: Month SEPT. Day 26 Year 1957

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 6, 1906

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES STROBEL ~~STROBLE~~

14. MOTHER'S MAIDEN NAME: Henrietta Kaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ALBERT T. THOMPSON — Address: 6614 POWHATAN ST. E. RIVERDALE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(b): Arteriosclerosis — 10 years ±
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-28, 1947, to 9-26, 1957, that I last saw the deceased alive on 9-24, 1957, and that death occurred at 8 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Hazard M.D. — ADDRESS (Street, city or town, state): 3409 Wisconsin Ave. N.W. — DATE SIGNED

PHYSICIAN'S NAME (Type): John H. Hazard — Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: 9-30-57

22c. NAME OF CEMETERY OR CREMATORY: Washington Nat.

22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. W. Lees Sons - Wash D.C. — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 27 57

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9822 CERTIFICATE OF DEATH

09841

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: 17 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGES GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4222 KENNEDY ST. HYATTSVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry Middle Last EDWARD THORPE
4. DATE OF DEATH: Month SEPT. Day 6 Year 19 57

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug.29th,1909
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic (Electrical)
10b. KIND OF BUSINESS OR INDUSTRY: Wash.Sub.San.Comm.
11. BIRTHPLACE (State or foreign country): Laurel,Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank B. Thorpe
14. MOTHER'S MAIDEN NAME: Maude Eva Brady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: Grace M.Thorpe, 4222 Kennedy St. Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH
161 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Larynx
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/5, 19 57, to 9/6, 19 57, that I last saw the deceased alive on 9/6, 19 57, and that death occurred at 4/10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William B. Hagan M.D.
ADDRESS (Street, city or town, state): 3303 Perry St.Mt.Rainier,Md.
DATE SIGNED: 9/6/57

PHYSICIAN'S NAME (Type): WILLIAM B. HAGAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/9/1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Colmar Manor,Pr.Geo.Co.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.W.Chambers Company, Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: SEP 11 57
24b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9823 Item 14 Film 220 9-17-57 et

Reg. No. 09842

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Col. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 5534 Bass Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James; Middle; Last Threats
4. DATE OF DEATH: Month Sept. Day 3, Year 1957
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-23-93
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Army
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leon Threats
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Crushed chest, abdomen and pelvis
DUE TO (c): Automobile accident

816x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Operator of an automobile in collision with a bus.
20c. TIME OF INJURY: Hour 6.30 p. m. Month, Day, Year 9-3-57 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Landover (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D.
EXAMINER'S NAME (Type): John T. Maloney, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: September 4, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-13-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Johnson & Jenkins
ADDRESS: 1804 Ga. ave N.W
24a. REC'D BY REGISTRAR DATE SEP 11 '57
24b. REGISTRAR'S SIGNATURE: W. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9824 CERTIFICATE OF DEATH

Reg. Dist. No. 09843

1. PLACE OF DEATH
a. COUNTY: Prince George
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma, Pk.
d. STREET ADDRESS: 6609 Popular
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma; Middle; Last Trussell

4. DATE OF DEATH: Month Sept; Day 11; Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-29-90

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Loudon County, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: B enjamin F. Mills

14. MOTHER'S MAIDEN NAME: Emma Holiday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Willie Trussell Husband
Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary emp. & edema
DUE TO
199.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma Frontis
DUE TO
(c): Primary not determined

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-5, 1957, to 9-11, 1957, that I last saw the deceased alive on 9-11, 1957, and that death occurred at 2:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel Schwartzbach M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type): Samuel Schwartzbach
1726 I. Street, N. W. Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: Leesburg Cemetery
22d. LOCATION (City, town, or county) (State): Leesburg, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: J Arthur Walters
ADDRESS: 254 Carroll St. NW D.C.

24a. REC'D BY REGISTRAR DATE: SEP 13 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9756 CERTIFICATE OF DEATH

09844
Reg. Dist. No. 245

1. PLACE OF DEATH
a. COUNTY: Prince George County
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Paint Branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Silver Spring 1556.2
d. STREET ADDRESS: 10204 Proctor St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First George Middle Sebastian Last Voneiff
4. DATE OF DEATH: Month September Doy 3 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar 17, 1893
9. AGE (In years lost birthdoy): 64 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Contractor (RET) Pluming, Heating
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Conrad Voneiff
14. MOTHER'S MAIDEN NAME: Pauline Toepfer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-18-8107
17. INFORMANT: Mrs. Clara Voneiff, 10204 Proctor St.
Address: Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Acute congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 4 mos
DUE TO (b): Rheumatic heart disease — 20 yrs
DUE TO (c):
Conditions, if ony, which gave rise to immediate cause (o), stating the underlying cause last. 416X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Lung abscess
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1957, to Sept. 3, 1957, that I last saw the deceased alive on Aug. 25, 1957, and that death occurred at 11:00 AM, from the causes and on the date stated abave.
ADDRESS (Street, city or town, state)
DATE SIGNED
ACTUAL SIGNATURE: Bennet A. Porter, Jr. M.D.
PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M.D. 9301 Colesville Rd. Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/6/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Humphrey
ADDRESS: Silver Spring, Md
24a. REC'D BY REGISTRAR DATE: Sept 6 1957
24b. REGISTRAR'S SIGNATURE: Mrs. Jas. Lavere Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09845 231

9825

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PRINCE GEORGES GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT of COLUMBIA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47 X-3
d. STREET ADDRESS: 1341 ADAMS ST. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle E. — Last WALTERS
4. DATE OF DEATH: Month SEPT. — Day 7 — Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	5-23-90	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	U.S.

13. FATHER'S NAME: Joseph Walters
14. MOTHER'S MAIDEN NAME: Mary ?????

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no			Dorothy E Walters	1341 Adams St N.E. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of liver & — INTERVAL BETWEEN ONSET AND DEATH
153X
DUE TO
(b): Jaundice Metastatic from colon (signid)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 5-6, 1956 to 9/7, 1957, that I last saw the deceased alive on 9/7, 1957, and that death occurred at 2:00 A.M. from the causes and an the date stated above.

ACTUAL SIGNATURE: George Hageage M.D. — ADDRESS (Street, city or town, state): 3717 - 38th Ave — DATE SIGNED: 9/7/57
PHYSICIAN'S NAME (Type): George Hageage. — Cottage City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Lincoln September 9th, 1957	Forest Lawn	Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Lee Funeral Home	Washington D.C.	Sept. 9-57	Carrie Campbell A. M. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09846

9852

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. County: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5417 Fisher Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills
d. STREET ADDRESS: 5417 Fisher Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HEDLEY Middle Last WELSBY

4. DATE OF DEATH: Month Sept Day 22 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 21, 1899

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rodman

10b. KIND OF BUSINESS OR INDUSTRY: Steel Worker

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Welsby

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Yes 578-07-4477

17. INFORMANT: Mary V. Welsby Address 5417 Fisher Rd. Temple Hills Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
420.1
DUE TO
(b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19___, to Sept 22, 19 57 that I last saw the deceased alive on Sept 13, 19 57, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A Palank M.D. — ADDRESS (Street, city or town, state): 5203 Silver Hill Rd Suitland Md — DATE SIGNED: 9-24-57

PHYSICIAN'S NAME (Type): EDWARD A PALANK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-25-57

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co. — ADDRESS: Washington, D.C.

24a. REC'D BY REGISTRAR DATE: SEP 24 '57

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09847

9826 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier 16
d. STREET ADDRESS: 4108 31st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FRANK Middle Last Williams

4. DATE OF DEATH: Month September Day 1 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 25, 1896 ~~June 10, 1894~~

9. AGE (At years last birthday) 61 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman Ret.

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Dept.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John William Williams

14. MOTHER'S MAIDEN NAME: Lucy May Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-22-4346

17. INFORMANT: Bernard F. Williams — Address: Son.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Bi. Pneumonia
DUE TO
581.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Esophageal Varices
DUE TO
(c) Cirrhosis Liver.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 15, 1957, to 1 Sept, 1957, that I last saw the deceased alive on 8/31/57, 19____, and that death occurred at 2:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Weintraut M.D.
ADDRESS (Street, city or town, state): 30 C Ridge Rd Greenbelt, Md
DATE SIGNED: 9/1/57

PHYSICIAN'S NAME (Type): William C. Weintraut

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/4/57
22c. NAME OF CEMETERY OR CREMATORY: National Mem. Park
22d. LOCATION (City, town, or county) (State): Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Funeral Home, Inc.
ADDRESS: Mt. Rainier, Md.

24a. REC'D BY REGISTRAR DATE: SEP 4 57
24b. REGISTRAR'S SIGNATURE: W. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9827 — 09848 Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain. Complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Deanwood Park
d. STREET ADDRESS: 5106 Nye Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Grant — Middle — Last Williams
4. DATE OF DEATH: Month Sept. — Day 6 — Year 1957
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 6, 1903
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Coal
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grant Williams
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. 1
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Martha Richardson; same as # 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH:

812X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Fractured skull, crushed chest and lacerations, multiple and severe.
DUE TO (c): Automobile accident

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): A pedestrian, run over by an automobile.
20c. TIME OF INJURY: Hour XX 11.00 p.m. — Month, Day, Year 9-6- 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Fairmount Hts, (County) Pr. Geo. (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John T. Maloney M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 9-6-57
EXAMINER'S NAME (Type): John T. Maloney, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-11-57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
22d. LOCATION (City, town, or county) Suitland, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S. Washington & Son — ADDRESS: 467 H St. N.W.
24a. REC'D BY REGISTRAR: DATE SEP 11 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9853

CERTIFICATE OF DEATH

09849

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beaver Heights
c. LENGTH OF STAY IN 1b: 4yrs

2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Beaver Heights
d. STREET ADDRESS: 1419-52nd Ave NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

3. NAME OF DECEASED (Type or print): First: Albert — Middle: — Last: Woods Jr.

4. DATE OF DEATH: Month: Sept — Day: 11 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 28, 1888

9. AGE (If years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: 4 — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Indust.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Albert Woods

14. MOTHER'S MAIDEN NAME: Ada. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 233-07-2347

17. INFORMANT (Name) Mrs. Ethel Hylton — Address: 1419-52nd Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mal Nutrition & Respiratory Paralysis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
331x
DUE TO (b): Paralysis of Throat and Esophagus. — 1 wk.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): Cerebral Hemorrhage and Paraplegia — 2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1953 to Sept 11, 1957, that I last saw the deceased alive on Sept 11, 1957, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert R Nelson M.D. — ADDRESS (Street, city or town, state): 4112 Grant St NE — DATE SIGNED: 9/11/57

PHYSICIAN'S NAME (Type): Robert R Nelson — Wash. 19, DC

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-14-57

22c. NAME OF CEMETERY OR CREMATORY: Carver Memorial

22d. LOCATION (City, town, or county) (State): Prince Geo. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Henry E. Washington & Sons 467 N St N.W.

24a. REC'D BY REGISTRAR DATE: SEP 16 '57

24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9828 CERTIFICATE OF DEATH

Reg. Dist. No. 11096

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PRINCE GEORGE GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 MITCHELLVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First BABY — Middle GIRL — Lost WRIGHT

4. DATE OF DEATH: Month SEPT. — Day 20 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-20-57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 9 — Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): —

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown.

14. MOTHER'S MAIDEN NAME: HENRIETTA WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: mother — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO
(b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-20, 1957 to 9-20, 1957, that I last saw the deceased alive on 9-20 1957, and that death occurred at 11:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John W. Perkins M.D. — ADDRESS (Street, city or town, state): 5301 Hamilton St. Hyatts — DATE SIGNED: 9/24/57

PHYSICIAN'S NAME (Type): John W. Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 22b. DATE THEREOF: 10/11/57 — 22c. NAME OF CEMETERY OR CREMATORY: Prince George's General Hospital — 22d. LOCATION (City, town, or county) (State): Cheverly, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Penn, Jr. Administrator — ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 16 57 — 24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2077182XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9851

CERTIFICATE OF DEATH

09850
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Andrews AFB, Wash. 25, D.C.
c. LENGTH OF STAY IN 1b: See Reverse
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Andrews AFB, Wash. 25, D.C.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Texas
b. COUNTY: Val Verde
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Del Rio
d. STREET ADDRESS: 900 East 6th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Melvin — Last: Wyman Jr.

4. DATE OF DEATH: Month: September — Day: 12 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7 July 1917

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot - U.S. Air Force

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Air Force

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Frank M. Wyman Sr.

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: 4080th Air Base Group
Address: M/Sgt Paul Lock, Laughlin AFB, Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Injuries, multiple, extreme — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Aircraft Accident
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Aircraft Crash, Full Particulars Unknown

20c. TIME OF INJURY Month, Day, Year: Hour, a. m. p. m. 2:25 ~~XX~~ Sept 12 1957

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Andrews AFB

20f. (City or town) (County) (State): Andrews AFB, Prince Georges, MD.

21. I certify that I attended the deceased from See Reverse, 19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at 2:25a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Reginald P. McManus M.D.
ADDRESS (Street, city or town, state): 1401st USAF Hospital Andrews Air Force Base Washington 25, D.C.
DATE SIGNED: 12 September 1957
PHYSICIAN'S NAME (Type): REGINALD P. MCMANUS CAPT, USAF (MC)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-17-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chamberlin Co.
ADDRESS: 517-11th St. S.E.
24a. REC'D BY REGISTRAR DATE: SEP 16 57
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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A corrected Certificate of Death will be prepared and forwarded if additional information is received concerning items presently indicated as unknown.

CERTIFICATE

I, the undersigned, while in performance of duties as Medical Officer of the Day, for the 1401st USAF Hospital, do hereby certify that I was summoned to the scene of the aircraft accident and found subject officer dead upon my arrival thereat. It is my opinion that death occurred approximately 10 to 15 minutes prior to my arrival.

Item 1c: Unable to determine, aircraft had not landed.

Reginald P. McManus

REGINALD P. MCMANUS
CAPT, USAF (MC)
Attending Physician

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9757

CERTIFICATE OF DEATH

09851 345 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mt Rainer, Md
d. STREET ADDRESS 4049 - 34 St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eulala Middle Last Zook
4. DATE OF DEATH Month 9 Day 7 Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W		1858	99 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY own Home
11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Rufus Thurston Jones
14. MOTHER'S MAIDEN NAME Mary Barr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address George R. Lee

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Immediate
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Artery Heart Disease — 20-30 years
DUE TO
(c) Advanced Arteriosclerosis — 40-50 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from July, 1957, to Sept 7, 1957, that I last saw the deceased alive on Sept 6, 1957, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert B. Trey M.D. ADDRESS (Street, city or town, state) 7105 Riggs Rd. Hyattsville, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Robert B. Trey

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/10/57	Fort Lincoln	Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch & Sons ADDRESS Hyattsville Md.
24a. REC'D BY REGISTRAR DATE SEP 11 1957
24b. REGISTRAR'S SIGNATURE James Lovejoy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55